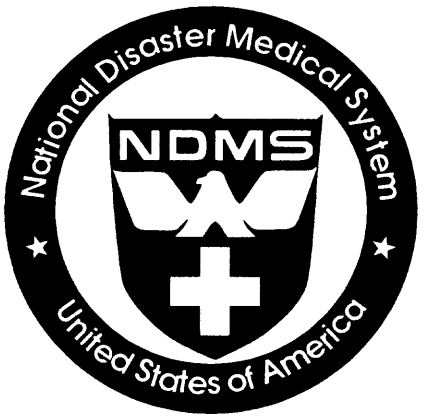


National Disaster Medical System

Federal Coordinating Center

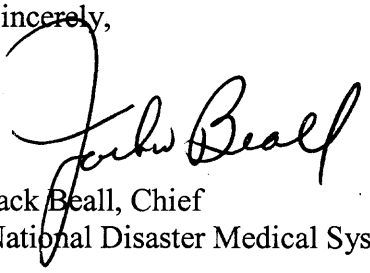
Guide

7 July 2006

FOREWORD

This guide is designed to assist Federal Coordinating Center (FCC) Directors and FCC staff members, as well as local officials in preparing for and conducting operations to receive and provide definitive medical care to patients evacuated from military contingencies or disasters as part of the National Disaster Medical System (NDMS). It is not prescriptive, but is provided in order to facilitate the coordination of planning and operations among the partners of the NDMS. Accordingly, this guide is endorsed for use.

Sincerely,



Jack Beall, Chief
National Disaster Medical System Section

Comments or recommended changes to this Guide may be sent by non-Federal users to the NDMS Executive Secretariat through the:

Chief, National Disaster Medical System Section
500 C Street SW
Washington, D.C. 20472

Federal users of this Guide should submit comments or recommended changes to either the

Office of the Assistant Secretary of Defense (Health Affairs) (OASD/HA)
Pentagon, Room 3E281
Washington, DC 20301-1200

or the

Department of Veterans Affairs (VA)
Office of Policy, Planning and Preparedness
Readiness Operations Center – Site B
VA Medical Center
Route 9, Bldg 500, Ste GD-114
Martinsburg, WV 25401

Additional copies of this Guide may be obtained from the above organizations. This document can also be downloaded from the NDMS website at http://ndms.dhhs.gov/index.html.

TABLE OF CONTENTS

INTRODUCTION	4
CHAPTER 1 – THE NATIONAL DISASTER MEDICAL SYSTEM	5
Organizational Components	5
Operational Overview	6
Medical Response	7
Patient Evacuation	7
Definitive Medical Care	8
Establishment and Disestablishment of FCCs and PRAs	9
CHAPTER 2 – NDMS ACTIVATION AND OPERATIONS	10
Introduction	10
NDMS Activation	10
NDMS Definitive Care Requirements Assessment	10
FCC Activation Stages	11
Mission Assignments	11
Coordinating NDMS FCC Operations	12
Coordinating Patient Regulating and Aeromedical Operations	12
Coordinating FCC Patient Reception Area (PRA) Operations	12
CHAPTER 3 – FCC ROLES AND RESPONSIBILITIES	15
Introduction	15
Represent the NDMS	15
Solicit/Organize Community Participation	15
Facilitate/Maintain Hospital Enrollment and Community Support	17
Collect/Report Hospital Bed Availability Data	17
Coordinate Training and Exercises	17
Coordinate Patient Reception Area Plans	17
Coordinate Local Patient Reception Operations	18
Coordinate Discharge and Return of Patients	20
Coordinate Financial Management	20
Facilitate Communications	20
ANNEX A – Facilitate/Maintain Hospital Enrollment and Community Support	21
ANNEX B – Hospital Bed Availability	24
ANNEX C – Training and Exercises	28
ANNEX D – Patient Reception Area Plans	30
ANNEX E – Patient Discharge and Return	35
ANNEX F – Financial Guidance	39
ANNEX G – Communications	44

ANNEX H – Summary of FCC Director and FCC Coordinator Duties 46
ANNEX I – Glossary of Terms and Abbreviations 49
ANNEX J – FCC PRA Assessment Survey 55
ANNEX K – Current FCCs 65
ANNEX L – References 67

INTRODUCTION

1. The National Response Plan (NRP) assumes that an Incident of National Significance may occur at any time with little or no warning in the context of a general or specific threat or hazard, involving single or multiple geographic areas, involving multiple, highly varied hazards or threats on a local, regional, or national scale. This may cause numerous casualties, fatalities, displaced people, property loss, and disruption of normal life-support systems, and basic infrastructure.

2. The NRP Emergency Support Function #8 (ESF #8) – Public Health and Medical Services Annex provides the mechanism for coordinated Federal assistance to supplement State, local, and tribal resources in response to public health and medical care needs for potential or actual Incidents of National Significance and/or during a developing potential health and medical situation. ESF #8 is coordinated by the Secretary of the Department of Health and Human Services (HHS) principally through the Assistant Secretary for Public Health Emergency Preparedness (ASPHEP). ESF #8 uses resources primarily available from HHS, the Department of Homeland Security (DHS) and other ESF #8 support agencies and organizations, including the Department of Defense (DOD) and the Department of Veterans Affairs (VA). NDMS is an asset utilized by ESF #8.

3. The Homeland Security Council, in partnership with the Department of Homeland Security (DHS), the federal interagency, and state and local homeland security agencies, developed fifteen all-hazards planning scenarios. These scenarios range from nuclear detonation or pandemic influenza outbreaks to earthquakes, hurricanes and radiological dispersal devices. Many of these scenarios project numbers of patients that may overwhelm state and local medical resources. The scenarios are for use in national, federal, state, and local homeland security preparedness activities.

4. In addition to the need for a system to provide expanded medical support for such disasters, there are national military needs that must be considered. The Department of Defense (DOD) medical planners have identified requirements for evacuation and definitive medical treatment in light of changing threats and changes in force structure, as well as the evolving technical advances in weaponry and medicine. These requirements have the potential to exceed the capabilities of the DOD. As a result of Public Law 97-174, the Department of Veterans Affairs (VA) and the DOD developed the VA/DOD Contingency Hospital System to provide a backup for the DOD Military Healthcare System (MHS). However, even this system may not be enough to meet the need for medical care in circumstances producing overwhelming numbers of patients.

5. The National Disaster Medical System (NDMS) combines Federal and non-Federal medical resources into a unified response to meet natural and man-made disaster needs, as well as support patient treatment requirements from military contingencies.

Chapter 1
THE NATIONAL DISASTER MEDICAL SYSTEM

1. The National Disaster Medical System (NDMS) is an asset sharing partnership among the Department of Homeland Security's (DHS) Federal Emergency Management Agency (FEMA), Department of Defense (DOD), the Department of Veterans Affairs (VA) and the Department of Health and Human Services (HHS) working with State and local governments, and the private sector. It is chartered in a Memorandum of Agreement (MOA) among these agencies.

2. In accordance with 42 U.S.C., Section 300hh-11, the purpose of the NDMS is, "to (i) provide health services, health-related social services, other appropriate human services, and appropriate auxiliary services to respond to the needs of victims of a public health emergency; or (ii) be present at locations, and for limited periods of time, specified by the Secretary on the basis that the Secretary has determined that a location is at risk of a public health emergency during the time specified." Authority to direct the NDMS was transferred in 2002 to the Secretary, DHS in accordance with 6 U.S.C, Section 313. The NDMS is currently designed to fulfill three main objectives:

a. To provide supplemental health and medical assistance in domestic disasters at the request of State and local authorities.

b. To evacuate patients who cannot be cared for in the disaster area to designated locations elsewhere in the nation.

c. To provide a nationwide network of voluntary, pre-identified, non-Federal acute care hospitals capable of providing definitive care for the victims of domestic disaster or military contingency that exceeds the medical care capabilities of the affected local, state, or Federal medical system.

2. Organizational Components.

a. NDMS Senior Policy Group – Consists of the Under Secretary, Department of Homeland Security, Emergency Preparedness and Response (Chairman); the Assistant Secretary of Defense (Health Affairs); the HHS Assistant Secretary of Public Health Emergency Preparedness, and the VA Under Secretary for Health. It determines policy and goals for the NDMS.

b. NDMS Executive Secretariat – Consists of one official from each of the four partner agencies. It provides management and supervision of the NDMS.

c. NDMS Medical Inter-Agency Coordination Group (MIACG) – Convened by the NDMS Executive Secretariat when required to coordinate the planning, alert, activation and de-activation of select FCCs in support of an operation.

d. Federal Coordinating Center (FCC) Work Group – Consists of one representative from each of the four partner agencies. It coordinates FCC training, exercises, assessments, communications, planning and operations for the NDMS.

e. Federal Coordinating Center (FCC) – A facility located in a metropolitan area of the United States responsible for day-to-day coordination of planning and operations in one or more assigned geographic NDMS Patient Reception Areas (PRA).

f. NDMS Steering Committee - Local hospital, medical, public health, public safety, emergency management and emergency medical services officials, representatives of voluntary organizations, and elected officials organized in an NDMS PRA to assist in the preparation of local NDMS operating plans, planning, and execution of system exercises.

g. Patient Reception Area (PRA) - A geographic locale containing one or more airfields; adequate patient staging facilities; and adequate local patient transport assets to support patient reception and transport to local voluntary, pre-identified, non-Federal, acute care hospitals capable of providing definitive care for victims of a domestic disaster, emergency, or military contingency.

h. Patient Reception Team (PRT) - A multi-function group consisting mainly of clinical staff, but also including appropriate support from medical administration and communications personnel, logistics personnel, and people acting as litter bearers and drivers.

i. FCC Director - A military medical treatment facility commander, medical center director, or other individual responsible for the management of an FCC and associated NDMS PRAs.

j. FCC Coordinator - A DOD, VA or other principal staff officer assigned to assist the FCC Director.

3. Operational Overview.

a. The NDMS generally supports domestic emergencies and disasters within the Emergency Support Function #8 (ESF #8) structure of the National Response Plan (NRP). The U.S. Department of Health and Human Services (HHS) is the primary agency for Emergency Support function #8 (ESF #8). Under ESF #8, HHS is responsible for overall coordination of medical response, patient movement, and medical care. In the event of an emergency or major disaster, the Governor of an affected State may request Federal assistance under the authority of the Robert T. Stafford Disaster Relief and Assistance Act, PL 100-707, as amended. The resulting Presidential declaration of an emergency or a major disaster triggers a series of actions coordinated by the DHS, which may include the activation of the NDMS. The Assistant Secretary of Defense (Health Affairs) may also request DHS activate the NDMS in the event of a military contingency. This is done when it is expected that the numbers of military patients will exceed the DOD and VA medical capabilities. Finally, in the event of a Public Health Emergency or an ESF #8 activation the Secretary of HHS can request activation of the NDMS.

b. The NDMS includes supplemental medical services deployable to a disaster site; a patient evacuation system; and pre-identified, volunteer, non-Federal hospitals to provide definitive medical care. The DHS Federal Emergency Management Agency (FEMA) deploys NDMS medical response assets, e.g., Disaster Medical Assistance Teams (DMATs), etc. The DOD, US Transportation Command's (USTRANSCOM) Global Patient Movement Requirements Center (GPMRC), in conjunction with other ESF #8 partners, coordinates patient evacuation operations. Day-to-day coordination of local NDMS patient reception area operations is accomplished by VA and DOD FCCs. NDMS steering committees assist in carrying out local coordination activities.

4. Medical Response.

a. The primary NDMS resources that provide supplemental medical assistance are the Disaster Medical Assistance Teams (DMATs). DMATs are foremost a community resource for supporting local emergency responders in multiple casualty incidents. They are assets that may be used to provide disaster medical response within their home state, and are also national resources that can be called upon to provide interstate aide. DMATs at a disaster site provide pre-hospital and/or emergency medical services. A DMAT may be employed, if available, in a local NDMS Patient Reception Area (PRA) to provide patient staging services. The basic DMAT is a volunteer group composed of about 35 people, including physicians, nurses, technicians, and other allied personnel. DMAT members are non-Federal volunteers who are placed on intermittent Federal appointments to facilitate activation, when necessary. When activated, DMAT members are Federalized employees of the DHS NDMS Section.

b. There are two levels of DMATs: "operational" and "developmental". "Operational" DMATs are capable of deploying to a disaster site within 12 to 24 hours to provide primary and acute care, triage of mass casualties, initial resuscitation, stabilization, advanced life support, and preparation of sick or injured patients for evacuation. Operational teams are required to provide emergency care within 30 minutes of arrival at a disaster site; be completely operational within 6 hours of arrival at a disaster site; have the capacity to sustain operations for 72 hours without external support; have the capability of sustaining 24/7 operations for 10 to 14 days with re-supply; and can operate in an austere fixed or temporary environment. "Developmental" DMATs are able to deploy as a team, but may not have all the equipment and supplies required to be self-sustaining in the field. They may have individual members sent to round out or augment them.

c. FCCs may assist with planning efforts, but are generally not responsible for coordinating the evacuation of patients out of an affected area. However, the DOD may choose to utilize a DOD FCC to both plan and coordinate the evacuation of patients out of an affected area.

5. Patient Evacuation.

a. The second key element of the NDMS is patient evacuation. In the event that the medical systems within a disaster area are overwhelmed, there may be a need for a system to move patients out of the disaster area. The DOD coordinates patient movement for the NDMS in collaboration with other ESF #8 partners, as required. The DOD USTRANSCOM Defense

Distribution Operations Center is the single manager for the movement of NDMS patients who require en route medical care, to include accepting requests for movement of NDMS patients out of the disaster area, regulating patients to definitive medical care, tracking patients between disaster area and definitive care reception sites, and coordinating patient transportation. Patient movement may be accomplished by sea, ground or air.

b. Transportation by sea may be accomplished through the U.S. Navy Military Sealift Command, the U.S. Coast Guard, the DoT, commercial companies, or through other agencies, as applicable.

c. Transportation by ground may be accomplished through the Military Surface Deployment & Distribution Command, the DoT, commercial companies, or through other agencies, as applicable.

d. Transportation by air may be accomplished through the USTRANSCOM's Air Mobility Command (AMC), the DoT, commercial companies, or through other agencies, as applicable.

e. The Aeromedical Evacuation System (AES) administered by AMC has unique aeromedical evacuation (AE) capabilities. It is used day-to-day for the transportation of the DOD patients and can be expanded when required. To support NDMS operations, the USTRANSCOM GPMRC formulates evacuation missions in conjunction with the Headquarters, 18th Air Force Tanker/Airlift Control Center (TACC) based on patient medical and medical equipment requirements, the location of available definitive care, and the availability of aircraft and crews.

f. The C-130 Hercules forms the backbone of the DOD AES in the Continental United States (CONUS). For deliberate planning purposes, the C-130 standard load is 50 patients. This aircraft has the unique capability of not requiring an improved runway for takeoff or landing. It can land on short stretches of interstate highway, in a desert region, or an open field, weather and soil conditions permitting.

g. To support military contingencies, the DOD, in cooperation with the Department of Transportation and U.S. commercial airlines can activate the medical component of the Civil Reserve Air Fleet (CRAF). The Boeing 767, the primary aircraft of the AE segment of CRAF, can be configured for 87 litters within 72 hours after the aircraft is made available for use by USTRANSCOM.

6. Definitive Medical Care. Patients evacuated from a disaster area for definitive medical care arrive at the respective FCC's PRA. The PRA generally operates from pre-identified airfield, bus station or railhead Patient Reception Sites (PRS). Patients are off-loaded, triaged and staged at the PRS pending further medical regulating and ground transport to a local NDMS hospital. The definitive medical care portion of the NDMS begins upon admission to the participating NDMS hospital. FCCs monitor the status of NDMS patients treated at medical facilities associated with their FCC. In addition, FCCs may assist in coordinating fiscal information to support the processing of financial claims reimbursement (as detailed in Annex F). FCCs may be called upon to help coordinate the discharge and transportation of patients returning to their point of origin, or other destinations, as authorized. Patients requiring continuing care are

returned as soon as appropriate care is available in the area from which they were evacuated and the patient can be transported safely. The FCC may be asked by local authorities to assist in arranging the return of the remains of patients who expire during their NDMS-sponsored care to the custody of family or other legally responsible person. Upon release of patients from the NDMS responsibility, any records of patients' care, and/or disposition of remains that may be held by the FCC are sent to the DHS NDMS Section.

7. Establishment and Disestablishment of Federal Coordinating Centers (FCCs) and Patient Reception Areas (PRAs).

a. Initiatives to create a new FCC or PRA, and initiatives to disestablish an existing FCC or PRA, might come from a number of sources for a variety of reasons. Generally however, any initiative should include the name of the FCC or PRA, and a point of contact regarding the initiative. It should detail the FCC or PRA location and geographic boundaries, and it should recommend an effective date for the establishment (or disestablishment as the case may be). The initiative should be routed for comment and recommendation through the department (e.g., VA or DOD) that will have responsibility to administer the new FCC or PRA (or the department administering an existing FCC or PRA being considered for disestablishment). The recommendation to establish or disestablish must be forwarded to the Executive Secretariat for action.

b. If approved, the initiative is forwarded to GPMRC for coordination (to ensure, for example, that appropriate airfields are identified and that automated codes are created for new FCCs or PRAs). The Executive Secretariat also ensures that DHS NDMS Section is informed so that appropriate changes can be made to the official list of FCCs and PRAs. Finally, all NDMS partners are informed of the approved change, and the responsible NDMS partner implements the change (i.e., creates or disestablishes the new FCC or PRA).

Chapter 2
FCC ACTIVATION AND OPERATIONS

1. Introduction. The NDMS is a part of a continuum of care that begins at the disaster site or the battlefield, and terminates with the patient's return home or, in the case of a military patient, their discharge from medical care and return to military duty, or medical discharge from service and referral to VA. The activation and operation of the NDMS must ensure the efficient and timely response, stabilization, evacuation, reception, hospitalization and definitive medical care of the patient.

2. NDMS FCC Activation. The NDMS FCCs may be activated in one of three ways:

a. In the event of a domestic peacetime disaster, the Governor of an affected state, on advice of local or county authorities, may request Federal assistance under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. The state requests assistance from FEMA. FEMA accepts the request and tasks the appropriate Emergency Support Function (ESF), which in this case is ESF #8, because it has responsibility for patient movement. A mission assignment is generated by FEMA. HHS, as the lead for ESF #8, coordinates the overall response in concert with the NDMS Federal partners. The mission assignment will articulate which FCCs are activated and will be transmitted to DOD and VA points of contact. The Office of the Assistant Secretary of Defense, Homeland Defense (ASD(HD) will coordinate through the Joint Director of Military Support (JDOMS) to activate DOD FCCs, as well as to provide appropriate patient evacuation support. The Undersecretary for Health, Department of Veterans Affairs (USH/VA) will activate VA FCCs. The activated FCCs will initiate Patient Reception Area (PRA) operations and execute patient reception plans.

b. A State Health Officer may also request NDMS activation by the DHS Under Secretary of Emergency Preparedness and Response in situations without Presidential disaster declaration. However, the state may be liable for costs incurred in this type of activation.

c. When the number of military patients exceed or are expected to exceed the capability of the DOD Military Healthcare System (MHS) and VA medical systems, the NDMS may be activated by request of the ASD(HA). The ASD(HA) notifies the DHS NDMS Section and authorizes NDMS Section to alert USH/VA. At this point, the ASD(HA) will notify the Services to activate select DOD FCCs, and the USH/VA to activate select VA FCCs. ASD(HA) will also notify the National Military Command Center and the Joint Chiefs of Staff, who will request appropriate patient evacuation support from USTRANSCOM through USNORTHCOM. There will also be communication between the ASD(HA) and the DOD Joint Director of Military Support (JDOMS) informing them of actions taken. The activated FCCs will initiate PRA operations and patient reception plans. DOD covers costs associated with this activation.

3. NDMS Definitive Care Requirements Assessment.

a. After a Presidential disaster declaration has been made, DHS will deploy an Emergency Response Team – Advanced (ERT-A), or other advanced assessment teams. The ESF #8

representatives on the ERT-A assess local health and medical requirements, including the potential need for patient evacuation.

b. The NDMS Executive Secretariat determines the level of FCC participation required. The Executive Secretariat may convene a medical inter-agency coordination group to assist in this process. FCCs and their associated PRAs may be activated regionally, incrementally and/or all together, and may similarly be de-activated regionally, incrementally and/or all together as appropriate and as situations evolve.

4. FCC Activation Stages. The NDMS Executive Secretariat informs the ASD(HD) and USH/VA, who in turn inform their respective FCCs that their Patient Reception Areas (PRA) have been alerted and/or activated. The following terms may apply:

a. FCC Alerted. Should patient requirements dictate the need for NDMS beds, a PRA under management of this FCC could be among the next to receive patients. However, patients are currently NOT being regulated to this PRA. This status does not necessarily authorize reimbursement of FCC and/or PRA expenses incurred preparing for possible reception of patients. FCCs could expect at least 24-hour notice of patient arrival.

b. FCC Activated. This status implies that FCC reimbursement for all patient reception activities is authorized. It signifies that patients are to be regulated, or have been regulated to a PRA under management of this FCC. Patients can be expected to arrive within 24 hours.

5. Patient Movement Mission Assignments. The patient movement Mission Assignment specifies the mission to be performed, certifies fund availability and authorizes the movement of non-DOD beneficiary patients. Unless otherwise specified, the following elements are expected to be part of any NDMS patient movement Mission Assignment or part of Sub-Taskings of a Mission Assignment:

a. Deployment of medical regulating and patient movement assets to facilitate patient evacuation from the disaster area, as well as expenses incurred to activate Patient Reception Areas.

b. Evacuation and medical treatment for patients directly affected by the disaster, patients in the disaster area needing care no longer available as a result of the disaster or emergency, or patients not affected by the disaster but occupying beds that could be used for admission of disaster victims.

c. Support for the evacuation, lodging, and feeding of medical attendants, non-medical patient attendants, interpreters, and others (such as personnel to assist children, the hearing/visually impaired or mentally handicapped) who are validated as necessary in order to facilitate the patients' medical care.

d. Assets to augment local and State resources to provide for evacuation to Regional Evacuation Points (REPs) within the disaster area.

e. Means of patient evacuation from the disaster area (e.g., ground ambulances, buses, rail, or AE) to locations where definitive medical care is available.

f. Medical care and transportation en route and at destination hospitals.

g. Lodging, feeding and other support for recovered patients awaiting transport home.

h. Transportation home of stable patients, recovering patients, medical attendants, non-medical attendants, interpreters, etc.

i. Medical and non-medical transportation to transport patients to and from embarkation and debarkation airfields and train stations.

6. Coordinating NDMS FCC Operations.

a. Nationwide coordination of FCC operations is accomplished by the NDMS Executive Secretariat through representation on a Medical Inter-Agency Coordination Group (MIACG). The MIACG coordinates the planning, alert, activation and de-activation of select FCCs in support of an operation.

b. Specific patient movement and reception missions are coordinated directly between the GPMRC and the FCC. Local patient reception and distribution operations are coordinated directly between the FCC and the local participating NDMS hospitals, as well as other local support organizations required to support patient reception operations.

7. Coordinating Patient Regulating and Evacuation Operations. Once patient evacuation has been determined to be necessary and a ESF #8 Mission Assignment or Sub-Tasking has been issued, GPMRC will issue bed-reporting instructions to those FCCs activated for patient reception. GPMRC will receive medical information about victims, determine medical equipment needed for ground or air transport. While GPMRC is not responsible for coordinating transport of patients to Regional Evacuation Points (REPs) in the disaster area, GPMRC will coordinate movement of patients out of REPs to the FCCs' PRA airport(s), and will communicate with FCCs regarding ground and/or aeromedical missions dispatched to evacuate patients from the disaster area to the PRAs. (Note: this process does not exclude the possibility that the requirement for immediate evacuation could be so great that the scope of information collected and furnished would be minimal.)

8. Coordinating FCC Patient Reception Area (PRA) Operations.

a. FCC Alerted. In this status, FCC Directors should:

- Conduct periodic bed reporting in accordance with GPMRC instructions (e.g., weekly).
- Maintain daily monitoring of USTRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES).
- Establish communications with all Patient Reception Team leaders, GPMRC, member hospitals, and other elements involved with FCC operations.

- Validate PRAs' throughput, i.e., ability to receive, triage, and distribute patients to member hospitals.

b. FCC Activated. In this status, FCC Directors should:

- Establish communications with GPMRC
- Continually monitor TRAC2ES to determine arrival time(s) and medical condition of patients.
- Conduct periodic TRAC2ES bed and throughput reporting in accordance with GPMRC instructions (e.g., daily).
- Preposition required equipment and a minimum cadre of personnel at the PRA.
- Ensure Patient Reception Team members are notified and standing by to assemble at the PRA.
- Ensure ground transportation assets are prepared to transport patients.
- Ensure receiving member hospitals are prepared to receive patients.
- Ensure other support elements are prepared to assemble at the PRA in accordance with the PRA Plan.

c. Prior to the arrival of patients, the FCC Director activates the PRA Plan, and ensures that local triage teams, litter bearers, administrative teams, patient staging teams, and transportation assets are alerted. Upon the arrival of patients, the FCC Coordinator notifies the GPMRC. The FCC Coordinator, or other designated agency or individual, will then further regulate and coordinate the movement of the patients to local NDMS participating hospitals.

d. The FCC Coordinator informs the nearest DOD medical treatment facility (MTF) when active duty DOD patients have been admitted to civilian hospitals of the NDMS. DOD MTFs coordinate with DOD agencies, NDMS hospitals, and other applicable agencies to ensure that all subsequent administrative actions are accomplished, to include: patient accounting; financial assistance to the patient; administrative, personnel and chaplain services; medical record keeping; casualty reporting (e.g., seriously ill, very seriously ill, etc.); re-equipping, re-supplying and transporting recovered DOD patients to duty; processing medical evaluation or physical evaluation board procedures for Temporary Disability Retirement Listing; and/or mortuary services. In military contingencies, a Military Patient Administration Team (MPAT) may be dispatched to the MTF or the FCC to assist in coordinating these actions.

e. GPMRC Liaisons may be dispatched to the FCC to assist in coordinating operations. GPMRC Liaisons are generally officers or senior enlisted medical administrative personnel under the operational control of the GPMRC. GPMRC Liaisons advise the FCC on GPMRC policies and procedures, and support the FCC's responsibilities for bed reporting and coordinating with the GPMRC via automated systems or manual means. GPMRC Liaisons facilitate coordination between non-Federal NDMS hospitals under the FCC's purview and DOD MTFs as required. GPMRC Liaisons may also assist the FCC in ensuring that required notifications are made and military patients are tracked. In the absence of Liaisons, GPMRC maintains staff available by telephone for consultation regarding the coordination of operations.

f. Patient Movement Items (PMI). Medical equipment and supplies used by the DOD to support a patient during evacuation are referred to as PMI. PMI must be certified for use in DOD aircraft by DOD testing agencies. When a patient requires evacuation, it is generally the originating hospital's responsibility to provide the PMI required to support the patient during evacuation. PMI often accompanies a patient through numerous stops and layovers from the originating hospital to the destination hospital. The PMI system supports in-transit medical capability without removing equipment from patients, works to exchange in-kind PMI without degrading medical capabilities, and should provide prompt recycling of PMI. During a contingency or domestic incident, the U.S. Air Force may establish a PMI Cell in the vicinity of the PRA in order to assist with the tracking, refurbishment, redistribution and return of PMI collected from destination hospitals.

Chapter 3
FCC ROLES AND RESPONSIBILITIES

1. Introduction. NDMS FCCs have critical roles to play in the successful organization and operation of the system in the local community or communities for which they have been assigned responsibility. These critical roles are summarized as follows:

- Represent the NDMS
- Solicit/Organize Community Participation
- Facilitate/Maintain Hospital Enrollment
- Collect/Report Hospital Bed Availability Data
- Coordinate NDMS Patient Reception Area Plans
- Coordinate Training and Exercises
- Coordinate Local NDMS Patient Reception Operations
- Coordinate Discharge and Return of Patients
- Coordinate Financial Management
- Facilitate Communications

2. Represent the NDMS.

a. Although all NDMS FCCs are coordinated by either military medical treatment facilities (MTFs) or VA Medical Centers (VAMCs), the role of the NDMS FCC transcends those affiliations. In many ways the NDMS FCC represents the Federal Government, in working with the civilian medical community as well as State and local authorities.

b. The Commander or Director of the facility is the FCC Director and has overall control and responsibility for this program. The FCC Director appoints and/or identifies the FCC Coordinator who is responsible for the day-to-day operation and readiness of this program. They should approach their communities and geographic PRAs as local agents for the broad Federal coalition that comprises the NDMS.

c. FCC Coordinators are the essential link in obtaining and maintaining community participation in the NDMS. As such, they must be sensitive and responsive to the unique economic, governmental, organizational, and political characteristics of their local communities; and tailor/adapt briefings presentations, meeting sites, and protocol considerations accordingly.

3. Solicit/Organize Community Participation.

a. Each FCC should have a community-based NDMS Steering Committee. While federally coordinated, the NDMS is built on local, regional, and state resources, emergency planning and structures. It is vitally important to actively involve state and local health associations and emergency management agencies, hospital councils, medical societies, and local Emergency Medical Services in planning for patient reception operations. The FCC Coordinator should collaborate with local, regional, and State disaster emergency services agencies, hospitals, and

disaster medical and public health services officers. Also influential in local disaster services are public safety officials, including both police and fire services. The FCC Coordinator should maintain an up-to-date list of resources and participants in the NDMS, with means of contact during and after normal working hours.

b. Major metropolitan areas of the nation are served by emergency medical transport services in their jurisdictions, and many have regional coordinating networks and disaster management responsibilities that parallel those of NDMS. In areas not served by regional EMS agencies, local or district public health officers may be responsible for disaster medical services.

c. Public sector emergency and disaster services personnel have many organizations of their own, notably disaster councils, emergency services associations, rescue and paramedic associations, and associations of communications officers. Where such organizations are based in the NDMS area, their support should be sought.

d. The academic community also has several potential sources of support. Academic medical centers frequently serve as trauma centers for the region. Prominent faculty members may be recognized as community leaders in emergency medical care. Many such medical centers have organized response teams for local disasters and might be favorably inclined to affiliate with the NDMS. Community colleges may possess emergency medical technician training programs (basic and advanced), and their faculties may also be involved in support of local disaster response.

e. The military reserve community is another potential source of support. The endorsement of prominent Reservists and National Guardsman who occupy positions of influence in the civil community may be helpful. Many of these are leaders of the local health care community.

f. Additional resource support may be sought from local businesses that may be directly involved in disaster response assets, such as pharmaceuticals, medical/surgical supplies, medical gases, uniforms, communications equipment, EMS equipment and vehicles. Local sporting goods stores, Army-Navy stores, or large chain stores may also be willing and able to support various aspects of NDMS.

g. Several voluntary agencies exist principally to serve emergency needs. Among these is the American Red Cross whose chapters span the nation. In many areas, other agencies such as the Salvation Army and other religious affiliated organizations, such as Saint Vincent DePaul Society are also active in disaster relief and should be considered as potential supporters of NDMS.

h. Early in the organizational and planning process, the assistance of these voluntary agencies will mainly be in the form of identifying leaders of the community emergency response network and other important contacts who should be educated about the NDMS. Later, as planning progresses, such supporters can be enlisted to assist in the promotion of the program, enrolling institutional participants, recruiting capable sponsorship, identifying leadership for NDMS response teams, and training of hospital personnel and response team members.

4. Facilitate/Maintain Hospital Enrollment and Community Support (see Annex A for details).

a. The FCC seeks voluntary commitments of beds from non-Federal hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA).

b. FCC Coordinators are encouraged, with the advance consultation and concurrence of the participating hospital Administrator or Chief Executive Officer, to obtain news media coverage of the agreement signing ceremony. Plaques or certificates signifying NDMS participation may be presented to hospital representatives at the signing.

5. Collect/Report Hospital Bed Availability (see Annex B for details).

a. As part of initial enrollment in the NDMS, non-Federal hospitals indicate in the NDMS Memorandum of Agreement (MOA) a total "minimum" and "maximum" number of beds to be committed.

b. When activated, FCCs receive specific instructions directly from the DOD GPMRC on the reporting of beds immediately available. Upon receipt of instructions, the FCC Coordinator collects immediate bed availability data from each participating NDMS hospital and reports to GPMRC.

6. Coordinate Training and Exercises (see Annex C for details). The FCC Director ensures that FCC staff, as well as applicable federal, state and local government and private sector personnel receive appropriate training in the operation of the FCC and PRA(s). The FCC Coordinator ensures that representatives of NDMS member hospitals, as well as representatives of local emergency management agencies, EMS agencies, public safety, police and fire services are provided annual orientation to the PRA plan. The FCC Coordinator ensures that FCC staff and other individuals designated to augment the FCC staff annually receive detailed education and training on their specific duties. Although some FCCs will conduct comprehensive exercises more frequently, FCC Directors should conduct a full-scale patient reception exercise at least once every three years.

7. Coordinate Patient Reception Area Plans (see Annex D for details). The FCC Director is responsible for ensuring the development, exercise, and evaluation of local PRA plans. Each PRA under the management of the FCC should have a separate PRA Plan, and these should be coordinated in order to evaluate overlapping requirements for limited resources. Each PRA plan should address, as a minimum, the following areas:

- Concept of Operations
- System Activation
- Alerting of Participating Hospitals
- Patient Reception
- Patient Administration
- Communications

- Transportation
- Personnel Administration
- Test (Exercise) and Evaluation
- Public Relations and Media Information

8. Coordinate Local Patient Reception Operations.

a. FCC Directors implement PRA plans as required by the specific activation notification. This may include, at full activation, alerting all member hospitals and all elements of the local patient reception and ground transport programs. FCC Directors may find it advisable to initiate local bed reporting in anticipation of receiving bed reporting instructions from GPMRC. FCC Coordinators should ensure that open communications and liaison are established with GPMRC for the receipt of regulating decisions, evacuation mission information, and patient medical data, when available.

b. FCC Coordinators should ensure that the FCC Director, the Patient Reception Team, local EMS coordinators, all affected hospitals, higher headquarters, installation commanders, and all other applicable agencies and individuals are notified when patients are regulated to the FCC. Depending on the information received from GPMRC, the FCC may elect to begin the process of regulating patients to specific local hospitals prior to the arrival of the patients. The FCC Director ensures that reception, sorting, triage, staging, transportation and hospitalization of arriving patients occurs efficiently. This includes being able to match the individual patients requirements for care with bed capabilities as reported by the participating NDMS hospitals. Accordingly, this implies close coordination between the Patient Reception Team, local EMS coordinators, the FCC, and GPMRC.

c. If available, DMATs may be deployed locally or from other metropolitan areas to support FCC patient reception and distribution of patients to participating NDMS hospitals. All DMATs are managed by the DHS FEMA Operations Support Center. Requests for DMAT support for local patient reception operations should be forwarded through chains of command to DHS FEMA Operations Support Center. Each DMAT should have the capability to operate a nominal 80-patient staging site at an airport or remote clearing operation in a disaster area. Multiple DMATs can be brought together to provide a higher level of medical capability in the form of an NDMS Clearing Staging Unit (CSU). Usually three DMATs are assembled to form a CSU. In addition to providing for patient reception, an entire CSU can operate a large clearing station in a disaster area, a 250-patient aeromedical staging unit, or (when appropriately augmented) a fixed refugee care site providing screening, ambulatory medical care, and intermediate nursing care for a population of up to 10,000 refugees. U.S. Public Health Service (PHS) Officers can also be deployed to support patient reception and distribution. Requests for PHS Officers in support of local patient reception operations should be forwarded through chains of command to the HHS Secretary's Operation Center.

d. Upon arrival of patients, the Patient Reception Team medical leader should receive a manifest and medical briefing from the aircraft's Medical Crew Director, or from the ambulance, bus or train's senior medical attendant. This briefing will help to ensure that the most severe cases are off-loaded first for immediate transportation or stabilization. Following the briefing,

patients are either (1) moved directly to awaiting transportation and taken to a hospital, and/or (2) off-loaded and transferred to a patient staging/holding facility based upon the severity of injuries, practicality, and availability of transport. In either case, trained and experienced personnel are required to unload the vehicle, identify, examine, sort, accompany, and transport the patients to the hospitals.

e. The FCC Director provides administrative support for patient control and proper patient accounting. The FCC Coordinator ensures that a tracking system is operational in order to maintain the location and status of each NDMS patient in the region. If possible, an estimated length of stay should be determined for each NDMS patient. If the PRA is activated for a military contingency the FCC Coordinator ensures that data is provided to the appropriate DOD medical personnel upon request.

f. The FCC Director assumes administrative responsibility for patients. This responsibility begins upon a patient's arrival and continues until authorization for NDMS care ceases. This may include when the patient is either discharged, deceased, transferred out of the PRA, returned home or, in the case of military patients, returned to the responsible service personnel system for processing and assignment to a military unit, or discharge from active duty, as appropriate. If available, a Military Patient Administration Team (MPAT) may be dispatched to the FCC to assist in coordinating administrative actions for military patients. Additionally, GPMRC Liaisons may be dispatched to the FCC to support the FCC's responsibilities for coordinating with GPMRC, and to ensure that notifications are made and military patients are tracked.

g. FCC Coordinators are responsible for ensuring that transportation is arranged to move patients from arrival sites onward to local NDMS member hospitals. FCC Coordinators should have procedures to obtain vehicles and personnel on relatively short notice to transport arriving patients.

h. A PMI system supports in-transit medical capability without removing equipment from patients, works to exchange in-kind PMI without degrading medical capabilities, and should provide prompt recycling of PMI. The handling and return of this equipment to the DOD requires the coordination of GPMRC, aeromedical crews, the PRA Patient Reception Team, the destination NDMS hospital(s), and the DOD medical treatment facility nearest to the PRA. The FCC plays a key role in facilitating coordination and communication among these organizations operating in a PRA, in order to facilitate the return of PMI to the nearest DOD medical treatment facility.

i. The medical staff of participating NDMS hospitals provide patient medical care. NDMS member hospitals may be asked to provide the following to the FCC Coordinator:

- A daily bed availability report,
- A daily admission and disposition list of NDMS patients (indicating the expected length of stay),
- A release of information authorization, and
- A narrative summary upon discharge of each NDMS patient.

9. Coordinate Discharge and Return of Patients (see Annex E for details). FCCs may be called upon to assist in coordinating the discharge and transportation of patients back to their point of origin or other destinations, as authorized. Transportation will be provided under the provisions of the original DHS Mission Assignment or Sub-Tasking, or as directed by HHS unless covered by the patient's health care insurer, or the patient does not accept transportation arranged by the Federal government. Patients requiring continuing care are returned as soon as appropriate care is available in the area from which they were evacuated and the patient can be transported safely. Patients requiring continuing health care or observation must be accepted by a physician, at their home location, prior to being returned. Patients not requiring medical care en route will be provided commercial transportation procured through government sources. The FCC may be called upon to assist representatives of the Department of Transportation leading Emergency Support Function #1 (ESF #1) in coordinating the travel of these returning patients. It is expected that civilian patients who are ambulatory and do not require en route care will be issued tickets on the most appropriate commercial carrier. The FCC may be called upon to assist in arranging the return of the remains of patients who expire during their NDMS-sponsored care to the custody of family or another legally responsible person.

10. Coordinate Financial Management (see Annex F for details). FCCs assist their departments in developing budgets and coordinating fiscal information to support FCC training, equipment, exercises, and operations.

11. Facilitate Communications (see Annex G for details). The FCC Coordinator is responsible for planning, testing, and coordinating communication procedures, processes, and equipment to support local patient reception and distribution operations. Planning must include backup processes in the event that primary systems are disabled by the disaster/event. The role of volunteers should not be overlooked in the area of communications. Local HAM and MARS radio operators can provide an invaluable service and often have existing communications equipment in place or available for disaster response.

Annex A
FACILITATE/MAINTAIN HOSPITAL ENROLLMENT AND COMMUNITY SUPPORT

1. Purpose. The purpose of this annex is to assist the FCC in recruiting and maintaining the support of hospitals and area agencies in Patient Reception Areas (PRAs).

2. Responsibilities.

a. The FCC Director is responsible for encouraging area hospitals' participation in NDMS, and for establishing and maintaining the support of government agencies, volunteer organizations, and others within the immediate area.

b. The FCC Coordinator is the field representative for the FCC and is responsible for coordinating local plans, exercises and other functional activities to ensure the day-to-day operational readiness of the local FCC program. This includes recruiting and maintaining Memoranda of Agreement (MOAs) with area hospitals, developing and maintaining a collaborative relationship with local or regional Emergency Medical Services (EMS) organizations, government agencies and other organizations appropriate for involvement in NDMS operations.

c. The FCC Coordinator is responsible for the day-to-day operational readiness of the FCC.

2. Procedures.

a. The FCC Coordinator seeks voluntary commitments of beds from non-Federal hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA).

b. The FCC's enrollment effort should target local general acute care hospitals operating 100 beds or more, although smaller hospitals should be considered, especially if they express a desire to participate or possess key specialty beds. There is no minimum in overall size of bed commitment for psychiatric hospitals. In general, NDMS participating hospitals should be within a 50-mile radius of the airport or military airfield that would be the likely arrival location of NDMS patients. If available, alternate airfields within 50 miles should be identified in the local Patient Reception Area (PRA) Plan and communicated to the DOD Global Patient Movement Requirements Center (GPMRC). This is to help ensure that local ground transport of patients to a participating hospital will require one hour or less. Hospitals beyond a 50-mile radius may be accepted for enrollment at the discretion of the FCC Director.

c. A hospital volunteering to participate in NDMS should complete a MOA. The MOA should be signed by the Chief Executive Officer (CEO) of the NDMS member hospital, and the FCC Director as the local representative of the NDMS. The FCC Director may delegate this authority in writing to the FCC Coordinator. This agreement should be prepared in two copies;

one for the NDMS files of the FCC, and one for the participating hospital. MOAs should be reviewed annually and renewed every three years.

d. As part of the MOA, participating hospitals agree to participate in training and exercises of the NDMS. Since JCAHO requires that hospitals conduct at least one external patient movement exercise per year, NDMS drills and exercises may be an ideal method of satisfying that annual requirement.

3. Program Development.

a. Although the NDMS is a federally coordinated program, FCC programs are built on the voluntary commitment of the local health care community.

b. FCC Coordinators should lay the groundwork by researching existing community emergency medical response plans, MOAs among local health care and/or EMS organizations, points of contact (POC) lists, bed reports, and exercise after-action reports (AARs). Study the FCC area of responsibility and identify potential primary and alternate airfields. Identify potential medical facilities in the area and draft an information package to provide to prospective enrolling hospitals, including an introductory letter from the FCC Director, a template enrollment MOA and a copy of the FCC Guide.

c. FCCs should schedule introductory meetings, as appropriate and provide an overview of the NDMS to potential participating hospitals. The FCC Coordinator must be prepared to describe to a potential participant the reason why their support and participation are critical to the success of the program, emphasizing mutual support locally, as well as nationally, and goodwill in the community.

d. FCC Coordinators are encouraged, with the advance consultation and concurrence of the participating hospital administrator or CEO, to obtain news media coverage of the MOA signing ceremony. Plaques or certificates signifying NDMS participation may be presented to hospital representatives at the signing.

e. The success of a FCC program also requires the active participation of numerous organizations that volunteer their support for the NDMS. Local agencies and organizations that should be considered for participation in the FCC program include:

- Hospital and medical associations
- Local, county, regional and state emergency management agencies
- Emergency medical services agencies
- Radio Amateur Communications for Emergency Services (RACES) and Amateur Radio Emergency Services (ARES) organizations
- American Red Cross Chapter(s)
- The Salvation Army
- Airport and port authorities
- Area transportation agencies
- Local military or veterans' organizations

- Volunteer organizations
- Medical/education training institutions
- Businesses
- Metropolitan Medical Response System (MMRS)
- The Local Emergency Planning Committee (LEPC)
- Others, as appropriate

Annex B
HOSPITAL BED AVAILABILITY

1. Purpose. The purpose of this annex is to assist the FCC in collecting and reporting beds available for use by the NDMS, through the GPMRC, Scott Air Force Base, IL, during wartime or domestic disasters.

2. Definitions:

a. Available Beds - Beds that are vacant as of 2400 hrs of the day previous to the day of the report, to which GPMRC can regulate and to which patients can immediately be transported. They must be in a functioning medical treatment facility set up and ready for all aspects for the care of a patient. Available beds must include supporting space, equipment, medical material, ancillary and support services and staff to operate under normal circumstances. Excluded are transient patient beds, bassinets, incubators, and labor and recovery beds. Beds are reported in categories as instructed by GPMRC.

b. Bed Report - The submission of a hospital's real-time capacity to receive, admit, and treat patients from a disaster or war, or the submission of a FCCs capacity, including all available NDMS beds, for hospitalization.

c. Capability - The maximum number of patients a facility can accommodate.

d. Capacity - The number of patients that a facility can accommodate at a given point in time.

e. Category - One of the specific areas of medical care used to identify the nature of a patient's illness/injury as well as to identify the capability/capacity of a hospital. The five contingency categories (as well as their TRAC2ES codes in parentheses) are:

- Critical Care (CC) – Adult or pediatric patients requiring sophisticated intervention to restore or maintain life processes to their dynamic equilibrium. This involves the requirement to provide immediate and/or continuous attention and monitoring using specialized facilities, equipment and personnel. Critical care beds are generally defined as those in licensed intensive care units.

- Medical/Surgery (MM-SS) – Patients having, or suspected of having, medical illness or disorders, as well as patients having, or suspected of having, diseases or injuries normally treated by surgery, not coming within the purview of a more specific medical specialty. Medical/surgical beds are generally defined as those licensed, certified or otherwise authorized, with adequate space, equipment, medical materiel and ancillary support services, and staff to operate under normal circumstances. Excluded are transient patient beds, bassinets, incubators, labor beds and recovery beds.

- Psychiatry (MP) – Patients who require specialized psychiatric care in a medical treatment facility, including patients with disorders defined by the American Psychiatric

Association as severe mental illness (schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, or autism). Psychiatric beds are generally defined as those supported by a licensed psychiatrist, or a licensed registered nurse, social worker, psychologist or professional counselor when those services are part of a treatment plan authorized by a licensed psychiatrist.

- Burns (SBN) – Patients having burn injuries meeting the American Burn Association's (ABA) burn unit referral criteria, including (but not limited to) partial thickness burns of 10% or more of the total body surface: all patients with third-degree burns of 10% or more of the total body surface; or patients with significant burns involving the face, hands, feet, genitalia, perineum or major joints. Burn beds are generally defined as those associated with burn centers on the joint ABA and American College of Surgeons (ACS) verification list.

- Pediatrics (MC) – Patients having, or suspected of having, diseases or injuries requiring the services of pediatric health care providers. Pediatric beds are generally defined as those supported by a licensed pediatrician.

f. Medical Regulating - The actions and coordination necessary to arrange for the movement of patients through the levels of care. This process matches patients with a medical treatment facility that has the necessary health service support capabilities, and also ensures that bed space is available.

g. Throughput - The maximum number of patients that can be received at the NDMS patient reception area, off-loaded, staged, triaged, transported and admitted to the destination hospital (or hospitals of the NDMS) within any 24-hour period. This is an estimate, subjectively derived from various considerations such as reception site and local transportation limitations, personnel limitations for patient reception, staging and transport, as well as any other factors deemed relevant.

3. Responsibilities. The FCC Director ensures accurate bed availability and throughput reporting to the GPMRC. To accomplish this, the FCC Coordinator:

- Provides training to member hospitals on the materials in this annex. This includes providing a means by which member hospitals can report available beds to their local FCC in a timely manner.
- Provides the GPMRC with primary and alternate points of contact to ensure 24-hour availability, as needed.
- Participates in nationwide NDMS and ad-hoc local bed reporting exercises.
- Alerts member hospitals when Patient Reception Area (PRA) activation is imminent.
- Canvasses member hospitals for the ability to participate in bed reporting and patient reception. Note: It is understood that local exigencies may, at times, preclude the participation of a member hospital in a particular NDMS contingency.
- Notifies member hospitals when PRA activation has occurred.
- Receives bed-reporting instructions from GPMRC through Service or VA channels, as appropriate.

- Reports PRA bed availability totals to the GPMRC in accordance with instructions.

4. Initial Bed Commitments.

a. As part of initial enrollment in the NDMS, non-Federal hospitals indicate in the NDMS MOA a total "minimum" and "maximum" number of beds to be committed. The "minimum" represents the number of beds the facility could make available within 24 hours of notification of NDMS activation. Normally, the "minimum" is the average daily staffed and equipped capacity of the hospital minus the average daily patient census. The "maximum" is the number of beds that could be made available within 72 hours. The "maximum" represents the facility's judgment as to additional staffed and equipped beds that could be provided if supplemental temporary staff are hired, overtime is authorized, and/or the hospital administration and medical staff defer admissions for elective surgery, discharge current patients early, and take other actions to surge beds.

b. Another factor that may determine initial bed commitments is the number of current hospital staff with duplicate privileges at other hospitals in the area, or with Armed Forces Reserve Components (including members of the National Guard). The number of staff having such commitments and the ability of the hospital to locate and hire temporary replacement personnel may affect the number of available beds, particularly during NDMS activation in support of military contingency operations. Therefore, it is advisable that local participating hospitals factor in the potential loss of those medical staff with privileges at multiple hospitals, as well as those Guard and Reserve personnel subject to mobilization.

5. Bed Reporting Procedures.

a. GPMRC maintains a database of DOD, VA and non-Federal NDMS member hospital capacity available to support wartime contingencies as well as domestic natural disasters and emergencies. In response to such events, GPMRC is prepared to immediately solicit bed reports to facilitate medical regulating, as directed by U.S. Transportation Command Surgeon General or as requested by the DHS.

b. When alerted or activated, FCCs will receive specific instructions from the GPMRC via Service or VA channels, as appropriate, for reporting of throughput and bed availability. The instructions typically include the time period during which reports are to be sent, the format to be followed, the mode of reporting, and points of contact. Upon receipt of instructions, the FCC Coordinator collects bed availability data from each participating NDMS hospital, consolidates this for the PRA and reports to GPMRC. Reports will be submitted by all NDMS member hospitals located in the activated PRA to the FCC Coordinator. Reports may be submitted using U.S. Transportation Command's web-based automated system, i.e., the TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES). Alternatively, bed reports may be submitted by voice, fax or e-mail using formats provided by the GPMRC. Regardless of the means of reporting, these reports include two key elements: Available Beds and Throughput.

c. In preparing to report bed availability to GPMRC, FCCs with multiple PRAs that involve separate reception sites must insure that bed reports are submitted separately for each PRA. If

these sites have not been previously established during the planning process, it may not be possible to accomplish this during active operations. FCC Coordinators should note that the selection of an airport must include coordination with the airfield and the FAA to ensure "first in, first out" privileges for the evacuation aircraft.

6. Determination of bed availability.

a. The starting point for determining the number of beds available is to determine whether trained staff is available to provide the services represented within each category. Then, workload factors need to be considered. That is, how many patients can the clinical staff treat and manage in a 24-hour period (which is a function of currently housed inpatients, services, staff, house staff, ancillary support staff, and materiel available). The final count reflects the best estimate of available hospital resources.

b. When GPMRC regulates patients to a PRA, the patients might not arrive immediately. Further, it may happen that subsequent bed reports are submitted before previously regulated patients arrive. Accordingly, the FCC Coordinator must ensure an accounting method is in place to account for patients regulated but not received in order to not overstate the number of beds available. The method used depends upon whether the FCC Coordinator assigns regulated patients to a particular hospital prior to actual patient arrival and reception.

c. In addition to the total count of beds in the various categories, consideration must also be given to the "throughput" ability of the PRA (see definition above). Though throughput is an estimate, it is critical to planning for patient movement to a PRA. For instance, it is not logical to regulate 250 patients to a PRA if only 100 patients can be received, triaged, transported and admitted to participating hospitals in a timely manner. That is not to say that only 100 beds should be reported. Both figures (bed availability and throughput) are important to GPMRC's ability to plan effectively.

7. Frequently Asked Questions.

a. What does it mean when the report indicates that a bed is available? When a PRA report shows 10 beds available, the expectation is that until another report says otherwise, GPMRC may immediately regulate and send up to 10 patients to that PRA.

b. Does the bed need to be vacant at all times until a military patient or disaster victim arrives? Not necessarily, but by reporting an "available" bed, the FCC makes a commitment to provide a bed for the patient, in the applicable category, on patient arrival.

Annex C
TRAINING AND EXERCISES

1. Purpose. The purpose of this annex is to assist the FCC in providing education and training opportunities to personnel in NDMS member hospitals as well as others within the PRA involved in bed reporting, patient reception and transportation.

2. References.

- The National Response Plan (NRP)
- NDMS Patient Movement Concept of Operations Plan (Draft)
- Local Patient Reception Area (PRA) Plan

3. Responsibilities. The FCC Director must ensure that FCC staff, PRA Patient Reception Team members, applicable federal, state and local government and private sector personnel receive appropriate training in the operation of the FCC.

4. General Provisions. As with any planning effort, the development of the PRA plan does not cease with its publication. Planning is a dynamic process that must not only periodically test the plan that is developed, but also provide feedback to the planner and the community to correct deficiencies or adjust the plan in view of changing circumstances. Equally important, exercise of the PRA Plan serves to keep it visible and viable.

5. Training.

a. As a minimum, the FCC Director should provide an annual orientation to the PRA Plan to representatives of NDMS member hospitals, as well as representatives of local emergency management agencies, Emergency Medical Service (EMS) agencies, police and fire services. At least annually, the FCC Director should ensure that Coordinators and other individuals designated to augment the FCC staff receive detailed education and training on their specific duties. Training of individuals can be didactic, practical, online or self-study.

b. In addition, specific group training drills should be conducted annually to ensure the preparedness of teams. These can vary in type and complexity, and can include tabletop exercises, functional area drills, team training, or other PRA-related events. These team training programs should be planned with specific goals in mind. Complexity and scope must be clearly defined. It is not necessary to provide training on the entire PRA plan at each training event, nor do all participants need to be included at all exercises. It is recommended that scenarios be changed for each training drills, rotating between natural disasters, terrorist incidents and military contingencies.

6. Recommended Training Opportunities.

- Emergency Management Institute (Online) Courses (FEMA) (via http://www.training.fema.gov/emiweb/)

- DOD Emergency Preparedness Course (Defense Medical Readiness Training Institute)
- TRAC2ES Training (GPMRC)
- Annual NDMS Conference
- NDMS Participating Hospital Resources and Awareness Level Training Course (via the EMSHG website at http://vaww1.va.gov/emshg/)

7. Exercises.

a. Although some FCCs may conduct comprehensive exercises more frequently, FCC Directors should participate in a full-scale patient reception exercise at least once every three years. Each hospital or agency participating in the NDMS should be afforded an opportunity to participate in these exercises. Exercises should be designed to meet JCAHO or AOHA external disaster drill accreditation criteria. Exercises should be sufficiently comprehensive to permit an assessment of participating hospitals/agencies ability to perform according to the area PRA Plan. Exercises should test PRA operations (i.e., patient reception, off-loading, triage and staging at airfields, bus or rail terminals, etc.; transportation of patients; patient reception at participating hospitals; patient tracking and communications). It is recommended that scenarios be changed for each exercise, rotating between natural disasters, terrorist incidents, and military contingencies.

b. Federal funds may be limited for compensation of non-Federal organizations and/or agencies to support participation in PRA exercises. Despite historic lack of funding, however, creative exercise opportunities can be developed through collaboration with the community at little or no cost.

c. DHS NDMS Section maintains a national schedule of exercises. Exercise results may be reported to the NDMS Section through established departmental (VA and DOD) channels.

Annex D
PATIENT RECEPTION AREA PLANS

1. Purpose. The purpose of this annex is to assist the FCC in developing patient reception plans for assigned Patient Reception Areas (PRAs).

2. Responsibilities.

a. The FCC Director is responsible for the development, exercise, and evaluation of local PRA Plans.

b. The FCC Coordinator ensures that a Patient Reception Team (PRT) is developed for each PRA and that each PRT remains viable through training and exercises. The FCC Coordinator maintains contact with appropriate authorities in each PRA, such as the leader of the PRT, and includes 24-hour contact information in each PRA Plan. The FCC Coordinator notifies all agencies involved when alert or activation of the FCC is anticipated.

3. Plan Development. The development of local plans is critical to the viability of the NDMS. The key to success is the thoroughness and effectiveness of local planning. Each local community in which the NDMS is organized is unique. The degree of sophistication of current community disaster planning and the availability of resources that can be incorporated into the PRA Plan will vary widely. Each PRA Plan must be tailored to its community. Local planning cannot be accomplished without the support, involvement, and coordination of the local medical and emergency planning communities. Most communities have an Airport Disaster Plan or a similar Mass Casualty Incident (MCI) Plan. In many instances, this can be used as a basis for the PRA Plan. In fact, it is advisable that the PRA Plan be based on existing plans when possible. At a minimum, the same people and organizations involved in the development of existing emergency response plans should help develop, test, and manage the PRA Plan. Each PRA Plan should address the following areas:

4. Concept of Operations.

- Provide a concise mission statement
- Define the Patient Reception Area of responsibility
- Briefly describe the roles and responsibilities of principle agencies, teams, and individuals
- Identify any applicable references, including the National Response Plan as well as any applicable state and local disaster plans
- Identify applicable state and local governmental and non-governmental bodies, including local Emergency Medical System agencies
- Identify primary and alternate airfields, rail and bus terminals
- Identify local resources for transporting patients
- Identify local resources for definitive medical treatment

5. PRA Activation.

- Describe the processes for NDMS activation of the PRA
- Describe the processes for alerting and augmenting the FCC staff
- Describe the processes for notifying local agencies of activation

6. FCC Operations.

- Describe FCC staff roles, responsibilities and shift schedules
- Describe FCC internal communications, logs, reports, etc.
- Describe control of access to the FCC

7. Bed Availability Reporting.

- Provide definitions of terms, including a list of medical categories
- Describe the processes for collecting initial and recurring bed reports, including "throughput"

8. Medical Regulating and Patient Evacuation to the PRA.

- Describe the role of the DOD Global Patient Movement Requirements Center (GPMRC)
- Describe the processes and procedures for coordinating patient movement missions between GPMRC and the FCC

9. Patient Reception and Staging.

a. Describe the patient reception site(s). Patients arriving from distant disaster sites or from military contingencies will generally be received at a single reception site in the PRA (e.g., an airfield, rail or bus terminal). The site should facilitate the off-loading of patients, the immediate evaluation and triage of patients, and the staging of litter and ambulatory patients prior to transport to local medical facilities. Close coordination is required with DOD, civil airport authorities, EMS providers, city emergency planners and other agencies and organizations as appropriate to ensure access to the site, adequate staffing, security, environmental control (heat, water, light), provision of food and drink, and communications.

b. Describe the roles and responsibilities of a Patient Reception Team (PRT). The PRT is a multi-function group and consists mainly of clinical staff, but should also include appropriate support from medical administration and communications personnel, logistics personnel, and people acting as litter bearers and drivers. The team leader can be a physician or other person with appropriate medical background. This team can be based out of a federal facility (VA or DOD) or comprised of volunteers from community organizations. Disaster Medical Assistance Team (DMAT) members and U.S. Public Health Service Officers may make exceptional PRT members if they are available to the FCC. Local Emergency Medical Service (EMS) volunteers who perform dispatch and ambulance transportation can also be helpful.

10. Transportation.

a. Describe resources, procedures and contact information to obtain vehicles, drivers and other personnel to transport patients from the reception site(s) to local NDMS member hospitals. It is important that all vehicles be assessed for their patient carrying capability, inventoried, and tabulated in the patient transportation plan. Additionally, advance coordination should be effected with the authorities that will make these vehicles and personnel available. Military vehicles that are scheduled to move to an overseas theater of operations early in mobilization, or are committed to a potential military mobilization effort, should not be included as patient transportation assets during military contingencies. Resources might include:

- Ambulances, other vehicles and personnel from local Emergency Medical Services (EMS)
- Military, VA, and/or local hospital ambulances and ambulance buses
- Commercial, governmental or other vehicles available that are wheelchair accessible or otherwise configured to accommodate litter patients
- Other commercial vehicles (e.g., airport limousines or buses)
- Military and other governmental general use trucks, vans, school buses, etc.

b. Describe the roles, processes and procedures for managing and tracking the use of local transport resources.

c. Identify primary and alternate routes from the patient reception site(s) to local medical facilities. Ensure advance coordination with local law enforcement agencies is made in the event that traffic control and additional security are needed.

11. Patient Administration.

a. Describe the roles and responsibilities of the FCC Coordinator. The FCC Coordinator assumes administrative responsibility for patients. This responsibility begins upon a patient's arrival and continues until the patient is either returned home or, in the case of military patients, returned to the responsible Service personnel system for processing and assignment to a military unit or discharge from active duty, as appropriate.

b. Describe the roles and responsibilities of Global Patient Movement Requirements Center (GPMRC) Liaisons, if available, and Military Patient Administration Team (MPAT), if available.

c. Identify contact information for each participating NDMS hospital for normal operating hours as well as for after regular working hours.

d. Describe the roles and responsibilities of each participating NDMS hospital. The patients' day-to-day medical management and care will be accomplished by the medical staff of that hospital. The hospital will provide medical care using its own procedures and forms. NDMS member hospitals should provide information to the FCC Coordinator, to include a daily admission and disposition list (indicating the expected length of stay) and a narrative summary upon discharge of the patient.

e. Describe the roles, processes and procedures for tracking patients in the PRA. Ensure that the following information is included in the tracking system adopted by the FCC:

- Patient name
- Social security or other identification number
- FEMA registration number
- Date of birth
- Medical regulating/diagnostic category
- Type of patient (i.e., directly injured/victimized by disaster or relocated/displaced by the disaster)
- Home address (if available)
- Next of kin, address and telephone number (if available)
- Admitting hospital, admission date, address, point of contact and telephone number for inpatients
- Local domicile (e.g., hotel or shelter), address, point of contact and telephone number for outpatients
- Military status and unit of assignment, as applicable

f. Describe policies and procedures for disposition of records. The FCC Coordinator generally retains patient data for the minimum period required by statutory law. The FCC Director will determine, in conjunction with legal advice from an attorney, the final disposition of this information. All appropriate patient confidentiality procedures, including protection of social security numbers, must be followed. All protected health information should be safeguarded in accordance with the Health Insurance Portability and Accountability Act of 1996.

g. Generally, the Department of Veterans Affairs confidentiality statutes and the Privacy Act permit disclosure of medical records to the Federal Coordinating Centers, to treating hospitals and to third party payers for medical care, e.g., insurance carriers, Medicaid and Medicare, without the consent of the patients. However, as to drug, alcohol, HIV, and sickle cell anemia treatment records, this information cannot be disclosed about deceased patients without following special procedures. See section 7332 (b) (3) of title 38, United States Code, or section 1.465 (b) of Title 38, Code of Federal Regulations. As to living patients, disclosure of this information is not permitted without prior written consent unless disclosure is made to medical personnel to the extent necessary to meet a bona fide medical emergency. However, the medical records of any patient, living or deceased, treated pursuant to NDMS, may be disclosed without consent after the drug, alcohol, HIV and sickle anemia treatment information has been blanked out.

12. Patient Movement Items Management. Describe the general provisions of a PMI system and identify points of contact at the nearest DOD military medical treatment facility.

13. Patient Discharge and Return.

- Describe roles and responsibilities for individual patient discharge planning

- Describe the processes and procedures for transporting patients who require continuing medical treatment
- Describe the processes and procedures for transporting patients who do not require continuing medical treatment

14. Financial Claims Processing.

- Describe basic procedures for data collection, claims processing and reimbursement
- Describe roles and responsibilities of the FCC Coordinator and NDMS participating hospitals

15. Training and Exercises.

- Identify the requirements and objectives for annual training of individuals
- Identify the requirements and objectives for annual training of teams
- Identify the requirements and objectives of triennial (or more frequent) comprehensive PRA exercises

16. Public Relations and Media Information.

- Identify local media resources
- Describe rules, limitations and processes for preparing information for release
- Identify local agencies and individuals authorized to release information

17. Communications.

a. Identify primary and alternate means of communication among, and provide a detailed contact list for the following (for normal operating hours as well as for after regular working hours):

- The FCC
- Appropriate headquarters elements or agencies
- GPMRC
- Local authorities and agencies
- Patient reception site authorities
- Patient reception teams
- Patient transport agencies
- All participating NDMS hospitals
- Others as required

b. Provide an inventory of primary and alternate communications equipment and supplies.

Annex E
PATIENT DISCHARGE AND RETURN

1. Purpose. The purpose of this annex is to assist the FCC if asked to help coordinate the return of NDMS patients from definitive care back to their home of record.

2. Responsibilities.

a. FCCs may be called upon to help coordinate the discharge and return transportation of patients to their point of origin or other destinations, as authorized. Transportation will be provided to the extent indicated by the original Mission Assignment unless covered by the patient's health care insurer or the patient does not accept transportation arranged by the Federal government. Patients requiring continuing care are returned as soon as appropriate care is available in the area from which they were evacuated and the patient can be transported safely. Patients requiring continuing care or observation must be accepted by a physician at their home location prior to being returned. The FCC Coordinator is responsible for tracking any FCC costs associated with return transportation.

b. GPMRC is the primary manager for coordinating the movement of all NDMS patients who require en route medical treatment, regardless of the mode of transportation. However, the Department of Health and Human Services (HHS) or their designated representative may take responsibility for coordinating the return of non-military patients requiring en route care.

c. Patients not requiring medical care en route may be provided transportation procured through other channels. The FCC may be called upon to assist representatives of the Department of Transportation, the Lead Agency for Emergency Support Function #1 (ESF- #1) in coordinating the travel of returning patients. Ambulatory civilian patients who do not require en route care will be issued tickets on the most appropriate commercial carrier. Patients who arrange their own transportation home may not be reimbursed for travel costs.

3. Patient Discharge Planning.

a. NDMS hospitals must communicate the post discharge requirements of the patients to HHS or their designated representatives in order to manage continuation of care, to include follow-up medications, daily personal needs, and to ensure transport is arranged prior to discharge.

b. NDMS hospitals should start discharge planning 72-hours prior to discharge. NDMS hospitals may have to augment their staffing to facilitate the discharge of large numbers of patients. If patients' homes are unsuitable or uninhabitable for return at the time of discharge, the FCC may be called upon to assist in coordinating patient support. Depending on the situation, the FCC Coordinator may be called upon to consult their headquarters element, the American Red Cross (i.e., the Lead Agency for Emergency Support Function #6 -Mass Care), the DHS Disaster Assistance Center, or other appropriate agencies or organizations to ensure that patients are registered for Federal Disaster Assistance and that temporary accommodations are secured through other local, State or Federal programs, as applicable.

4. Returning Patients Requiring En Route Care.

a. Attending physicians in NDMS hospitals will identify the readiness of patients for movement 72 hours (at a minimum) prior to transfer. Depending on the situation, requests for patient movement are provided to HHS or their designated representative. If HHS coordinates the return of patients, there will likely be minimal involvement by FCCs.

b. Alternatively, the Mission Assignment or Sub-Tasking may direct that such requests for patient transfer be provided to the GPMRC. In this case, the FCC Coordinator may be called upon to assist the requesting hospital in submitting a Patient Movement Request (PMR) to GPMRC. Patients requiring continued inpatient care or observation will not be discharged from the NDMS member hospital until the day of transportation.

c. Patients will not be considered for return transportation until the attending physician determines that the patient can be transported safely, and that appropriate continuing care is available in the area from which they were evacuated. Confirmation is required from a physician at the destination who is willing to accept and admit the patient or otherwise assume responsibility to follow the patient if continuing care is needed on an outpatient basis. For patients moving to another inpatient care facility, the accepting physician must agree to the transfer. NDMS is not obligated to pay for return transportation of patients (or their family) who decline coordination for transportation by the Federal government. The FCC Coordinator may be asked to help document the declination.

c. A separate PMR must be submitted for each patient. The exact format and method will be specified by HHS, their designated representative, or by GPMRC. However, at a minimum all PMRs will identify the following:

- Individual patient's name
- Social security or other identification number
- Diagnosis
- Date/time that the patient is ready for evacuation
- Any special equipment or patient movement item requirements
- The location of the patient(s) (e.g., the originating medical facility, staging facility, mass care facility, hotel, etc.)
- Military status and unit of assignment, if applicable

d. Attending physicians at medical facilities who report patient movement requirements should be prepared to provide as much medical information as possible on patients (e.g., current condition, diagnosis, vital signs). Additional information may be sought by HHS, their designated representative, or by GPMRC. These agencies will also specify a reporting methodology, i.e., voice, phone, fax or e-mail. A point of contact at the patient's location should be provided so that HHS, their designated representative or GPMRC can obtain any additional information needed.

e. HHS, their designated representative or GPMRC will review and return the PMR to the NDMS hospital with an approval or disapproval. They may disapprove pending additional patient information, or if they deem evacuation to be dangerous to the patient. Otherwise, HHS, their designated representative or GPMRC will coordinate aeromedical (or other transportation) missions directly with the NDMS hospital and/or the FCC. The NDMS hospital and/or the FCC will be informed of the aircraft mission itinerary and schedule. As applicable, the HHS, their designated representative or FCC arranges transportation from local facilities to airfields or other point of embarkation.

f. In preparing a patient for evacuation, the patient's attending physician or other primary medical care provider should consider the care needed both en route and at potential interim stops. (Aeromedical evacuation missions often include multiple stops to accommodate other patients' requirements, refueling, and/or crew rest limitations.) For questions relating to en-route care, the care provider should consult with the validating flight surgeons and flight nurses at GPMRC. The attending physician has responsibility for reporting the patients' medical requirements, for initial documentation of medical treatment, and for provision of medical supplies and equipment to the extent possible.

g. The mode of return transportation (the DOD aeromedical evacuation system or commercial air travel being considered the preferred modes) will be determined utilizing the most cost-effective alternative, in coordination with the patient, the patient's family, the attending physician, and the FCC Coordinator. For patients requiring en route medical care, HHS, their designated representative or GPMRC will coordinate ground transportation from the destination airfield to the destination medical treatment facility.

h. Any disclosure of patient medical information must comply with applicable records confidentiality statues (see Annex D).

5. Deceased Patients.

a. Military patients who expire during evacuation or following admission to an NDMS hospital will be handled in accordance with Service policies, regulations, and procedures. The nearest applicable MTF should be notified of the patient's death to arrange for final disposition. Civilian disaster victims who expire during evacuation or following admission to an NDMS hospital will he handled in accordance with procedures established by the local medical examiner or coroner. Upon learning of the death of a civilian NDMS patient, the FCC Coordinator will notify the DHS FEMA National Response Coordination Center (NRCC), 1-800-634-7084. The NRCC will assist in determining if and how the deceased will be returned to his/her community for final disposition. For military patients, the applicable MTF should be notified of the patient's expiration to arrange for final disposition. FCCs may be called upon to assist with burial arrangements in accordance with the original Mission Assignment when no legal custodian is identifiable.

b. The FCC may be called upon to assist local authorities, their respective headquarters element, or appropriate representative of the Department of Health and Human Services, the Lead Agency for ESF-8 (Health and Medical Services) in arranging for the return of the remains

of patients who expire during their NDMS-sponsored care to the custody of family or other legally responsible persons.

6. Documentation. Upon release of patients from NDMS responsibility, all records of patients' medical care and/or disposition of remains that may be held by the FCC are sent to the DHS NDMS Section. All patient information must be maintained in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Annex F
FINANCIAL GUIDANCE

1. Purpose. The purpose of this annex is to provide additional guidance regarding the funding and reimbursement process for training, equipping, and exercising of FCCs and their Patient Reception Area(s); for medical care, transportation, and other costs related to patient reception operations; and for claims reimbursement processing.

2. Patient Reception Area (PRA) Pre-Activation Expenses.

a. Exercise Funding. There are currently no separate monies available within the Department of Veterans Affairs (VA) or the Department of Defense (DOD) to support exercises (e.g., money to reimburse local ambulance companies, or for food for exercise volunteers, or rental of portable toilets, etc.). VA Area Emergency Managers (AEMs) are provided an annual budget of .001 (supplies) money and may use some of these funds to pay for limited expenses for patient reception exercises. Regular expense approval procedures are to be followed. In addition to regular .001 monies, VA requests for specific exercise expenses may be submitted through channels to the Emergency Management Strategic Healthcare Group (EMSHG) for funding. DOD FCCs should follow Service or facility procedures to request funding for exercise costs.

b. Pre-Activation Costs. There is generally no funding available for pre-activation costs (such as rental charges to set up in a hangar or to procure equipment). FCCs should be cautioned not to obligate funds for leases or other ongoing charges related to the Patient Reception Area without proper authority. However, negotiating no-cost, stand-by plans to be enacted upon NDMS activation may be warranted, when authorized by appropriate contracting officials. Stand-by contracts may be useful to meet pre-event planning requirements. If costs are unavoidable, VA AEMs should submit a request through channels to EMSHG to provide special funds to pay these charges.

3. PRA Activation Expenses. The Mission Assignment or Sub-Tasking will specifically stipulate funding scope and authority (e.g., whether from DOD or DHS). ASD(HA) or VA Emergency Management Strategic Healthcare Group will ensure that non-direct care expenses related to providing definitive care is reflected in the mission tasking from DOD or DHS.

4. PRA Operational Expenses.

a. The FCC Director, or the designated fiscal authority, will collect bills for appropriate charges for those services incurred by the FCC during PRA operations. Bills for goods and services born by FCCs will generally be paid by the FCC Director and forwarded to the Department of Homeland Security (DHS), Emergency Preparedness and Response, NDMS Section for reimbursement. Legitimate expenses related to the operation of the PRA should be supported by the Mission Assignment or Sub-Tasking. If the PRA is activated and told to expect to receive patients, expenses incurred as a result of this activation are expected to be eligible for reimbursement.

b. FCCs may coordinate through their chains of command to request Disaster Medical Assistance Team (DMAT) or U.S. Public Health Service (PHS) assistance for PRA operations. The DHS FEMA Operations Support Center manages DMAT operations. Requests for DMAT assistance are forwarded to DHS. The HHS Secretary's Operations Center manages the PHS. Requests for PHS assistance are forwarded to HHS. As in all requests for outside assistance, VA and DOD must be able to show the need for the request, and the request must be supported by the Mission Assignment or Sub-Tasking.

c. Civilian personnel costs are also eligible for reimbursement under some conditions. For example, if a city fire department provided personnel to help with triage, these costs would generally be eligible for reimbursement. It is the responsibility of the FCC to keep accurate records as costs accrue. It is suggested that all agencies that request reimbursement for personnel costs provide estimates on a daily basis as they occur.

d. VA personnel costs are also eligible for reimbursement under some conditions. Regular shifts worked by VA personnel at a PRA instead of the normal VA duty station are generally not eligible for reimbursement. However, overtime, weekends and holiday expenses are eligible for reimbursement.

e. Expenses for the use of hangars, including electricity, water, security, and other related expenses are generally eligible for reimbursement. These costs must conform to expenses for similar services in the area.

f. Expenses for the use of office supplies, furniture rental, equipment rental, computers, faxes, and other related operations expenses are generally eligible for reimbursement. These costs must conform to expenses for similar services in the area. Usually, expenses for equipment rental and furniture rental are appropriate, but purchase of these items may require written justification. Other costs (such as costs to transport a patient reception team) that cannot be assigned to individual patients but are necessary to the operation of the PRA, are generally eligible for reimbursement, so long as they can be justified as necessary. Documentation is critical.

g. Patients may be held at a staging facility, at the PRA, at a mass care facility, or even at a hotel near the airfield as they wait for transportation to another FCC, their unit of record, or to their home of record. Costs associated with this delay in transportation are generally eligible for reimbursement. These costs could include: hotel expenses, food, toiletries, clothing, ground transportation and/or commercial airfare. However, if adequate facilities are offered and those facilities are turned down or refused, generally no reimbursement is allowed.

h. Payments for direct services from the Salvation Army, Red Cross, or other Non-Governmental Agency (NGA) are generally eligible for reimbursement as long they are justified as necessary for the health and/or welfare of the patient. Documentation is critical.

i. Medical and transportation expenses (such as cost to transport the reception team) that cannot be assigned to individual patients, but are necessary to the operation of the PRA are eligible for reimbursement when they are justified as required for operation of the PRA. Accurate record keeping is critical.

5. Basic Provisions of Financial Claims Processing.

a. All claims for financial reimbursement associated with NDMS patient movement, reception, and treatment are subject to the provisions of the Federal Emergency Management Agency (FEMA) Mission Assignment or Sub-Tasking, the appropriate Department of Defense (DOD) authorization, or other authorizing document.

b. National Disaster Medical System (NDMS) member hospitals identify whether or not the patient maintains a primary and/or secondary third party payer for medical care (i.e., insurance carrier, Medicare, Medicaid, etc.) and will first submit billing for patient care services to the patient's identified third party payer(s) for reimbursement.

c. NDMS will be payer of last resort to any other existing medical coverage, except Medicaid, which by law is payer of last resort. Compensation for NDMS related claims will be reimbursed at rates contracted at the time of the disaster for the disaster related diagnoses.

d. HHS provides medical claims processing services for the NDMS, to support participating hospitals, providers and qualified beneficiaries affected by a national disaster.

6. Responsibilities for Financial Claims Processing.

a. The FCC Director or the FCC Coordinator:

- Provides HHS with contact information to NDMS member hospitals in order to facilitate medical claims processing.
- Provides specific claims processing instructions to NDMS member hospitals (as provided by HHS).
- Provide patient validation data to HHS.
- Collects appropriately billed charges for support services incurred by the FCC during patient reception operations, and provides them to DHS NDMS Section for reimbursement.

b. NDMS member hospitals:

- Identify patients' primary and secondary third party payers and submit billing for patient care services to the patient's identified third party payer(s) for reimbursement.
- Provide a daily bed availability report, a daily admission and disposition list (indicating the expected length of stay) to the FCC Director.
- Provide a narrative summary upon discharge, transfer or death of patients to the FCC Director.
- Submit Affidavit of Non-insurance for uninsured patients and submit associated final bills for payment directly to the appropriate Fiscal Intermediary.

c. Any disclosure of patient information must comply with applicable records confidentiality statues (see Annex D).

7. Claims for Medical Care of Civilians. It is expected that the Mission Assignment or Sub-Tasking will authorize the reimbursement of NDMS member hospitals, physicians and other care providers for medically necessary care of certified NDMS patients for diagnoses directly resulting from the disaster or emergency, and will generally not compensate for pre-existing conditions, except as they directly impact the medically necessary care authorized by NDMS. However, it is expected that that the Mission Assignment or Sub-Tasking will authorize the direct reimbursement of NDMS member hospitals, physicians and other care providers for medically necessary care of certified NDMS civilian patients for injuries or illnesses affected by the disaster or emergency, that is, when that care is not available in the disaster area.

8. Claims for Medical Care of Military Beneficiaries. The DOD will directly reimburse NDMS member hospitals, physicians and other care providers for healthcare services provided to patients who are beneficiaries of the Military Healthcare System (MHS) in accordance with the payment rules stated in Title 32 to the Code of Federal Regulations (32 CFR), Part 199. Final bills for payment are submitted by NDMS member hospitals, physicians and other care providers to the appropriate TRICARE Managed Care Support Contractor for the patient's command.

9. Claims for Transportation of Civilians. Claims for reimbursement for transportation of civilian patients are submitted to DHS in accordance with the Mission Assignment or Sub-Tasking.

10. Claims for Transportation of Military Beneficiaries. Claims for reimbursement for transportation of beneficiaries of the Military Healthcare System (MHS) will be submitted to the Military Medical Support Office (MMSO), PO Box 886999, Great Lakes, IL 60088-6999, at (888) 647-6676.

11. Claims for Other Costs. The expense of FCC patient reception activities will be reimbursed only as stipulated by the DOD or by the DHS Mission Assignment or Sub-Tasking. The FCC Director, or the designated fiscal authority, will generally pay appropriate billed charges for goods and services incurred by the FCC during patient reception operations. Bills are submitted to DHS for reimbursement.

12. Patient Validation and Tracking Data Collection.

a. The following elements must be submitted by the FCC to HHS or their designated representative as soon as possible, but no later than within seven days of the patient's arrival in the FCC Patient Reception Area (PRA),:

- Name of disaster, emergency or contingency
- FCC name and telephone number
- Patient name
- Patient date of birth
- SSN (or other unique patient identifier if SSN not available)
- FEMA registration number
- Admitting hospital

- Date of arrival at the PRA
- Date of hospital admission
- Diagnostic category
- Type of patient (i.e., directly injured/victimized by incident or indirectly affected, relocated or displaced due to the incident)
- Non-Hospital Destination

b. Within seven days of the patient's release from NDMS care, the FCC must provide HHS or their designated representative with the date of discharge, transfer or release.

► **Inpatient Medical Expense Payer Chart:**

Patient Affiliation	Patient Category	Priority of Payers
DoD	Active Duty	TRICARE
DoD	Dependents of Active Duty	TRICARE
DoD	Retirees	TRICARE
DoD	Retirees' dependents under 65	TRICARE
DoD	Retirees' dependents over 65	1st = Medicare 2nd = TRICARE
Civilian	All	1st = Individual or Group Insurance 2nd = Medicare 3rd = NDMS 4th = Medicaid

► **Outpatient Medical Expense Payer Chart:**

Patient Affiliation	Patient Category	Priority of Payers
DoD	Active Duty	TRICARE
DoD	Dependents of Active Duty	TRICARE
DoD	Retirees	TRICARE
DoD	Retirees' dependents under 65	TRICARE
DoD	Retirees' dependents over 65	1st = Medicare 2nd = TRICARE
Civilian	All	1st = Individual or Group Insurance 2nd =Medicare 3rd = Medicaid

13. Military Patient Case Management. Case management of active duty personnel in civilian hospitals is done daily across the nation. Case managers coordinate issues with the attending physician. Some of the issues addressed are: determining the type of care provided, transfers to another facility, required notifications, and expected date of discharge. Many times these activities are performed by the active duty medical center nearest the hospital in question. It may also be done by the TRICARE Contractor in an FCC's area. In particular, inter-facility transfers of active duty patients that might be affected under existing TRICARE contracts are not coordinated through GPMRC.

Annex G
COMMUNICATIONS

1. Purpose. The purpose of this annex is to assist the FCC in managing communication procedures, processes, and equipment in regard to patient reception operations.

2. Communications Inventory. Below is a listing of the communications equipment and suggested maintenance testing that is the recommended (minimal and supplemental) equipment for effective communications during contingency operations.

3. Recommended Minimum Equipment and Frequency of Testing. This list is not a required list of equipment for every FCC. This list is provided to show types of equipment that may be useful in running an efficient FCC, as well as (parenthetically) a recommended frequency for testing that equipment.

- Laptop computer with cellular modem access and alpha paging software (As needed)
- Printer (As needed)
- Fax machine (As needed)
- STU III Phone (Quarterly)
- Satellite phone with auxiliary antenna (Monthly)
- Cellular phone with backup batteries (As needed)
- VHF 7-10 channel, 5-watt handheld radio with charger and extra battery (As needed)
- Family Radio System (FRS) (As needed)
- Weather radio with battery backup (Weekly)
- Pager (As needed)
- Uninterruptible Power Supply (UPS) (Semi-annual)
- Auxiliary power (Quarterly)

4. Recommended Supplemental Communication Supplies.

- Locked cargo boxes with wheels or luggage carriers
- Telephone cords with connectors
- Extension cords with surge protectors
- Electrical toolkit with flashlight
- Batteries

5. Training. The FCC Coordinator should be familiar with equipment operations. Equipment manuals should be kept in a central location within the FCC office.

6. Exercising. FCC Equipment familiarization and testing should be built into FCC exercises.

7. Additional Communication Resources.

- Shared Resources (SHARES) HF radio program,
- Government Emergency Telecommunications Service (GETS),
- Hospital Emergency Administration Radio (HEAR),

- Amateur ham radio clubs,
- Other local community resources.

Annex H
SUMMARY OF FEDERAL COORDINATING CENTER (FCC) DIRECTOR AND FCC COORDINATOR DUTIES

1. Purpose. The purpose of this annex is to summarize the duties of both the FCC Director and the FCC Coordinator, as detailed elsewhere in this FCC Guide.

2. FCC Director.

a. Appoints and/or identifies the FCC Coordinator responsible for the day-to-day operation and readiness of the FCC.

b. Establish and maintain the support of area hospitals, government agencies, volunteer organizations and others within the immediate area.

c. Ensure the development, exercise and evaluation of local Patient Reception Area (PRA) Plans.

d. Although some FCCs will conduct comprehensive exercises annually, FCC Directors should conduct a full-scale exercise at least once every three years.

e. Ensure that FCC staff, as well as applicable federal, state and local government and private sector personnel receive appropriate orientation or training in the operation of the FCC.

f. Activate local PRA plans as indicated in activation notifications.

g. Ensure that bed availability reporting, as well as reception, sorting, staging, transportation and hospitalization of arriving patients occurs efficiently.

h. Provide administrative support for patient control and proper patient accounting.

3. FCC Coordinator.

a. Ensure the day-to-day operation and readiness of the FCC.

b. Establish and maintain active participation and support of local non-Federal acute care hospitals, involve state and local health associations, emergency medical services (EMS), emergency management agencies, hospitals councils, medical societies, public safety, police and fire services.

c. Maintain an up-to-date list of local NDMS resources and participants.

d. Ensure that representatives of NDMS member hospitals, as well as representatives of local emergency management agencies, EMS agencies, public safety, police and fire services are provided annual orientation to the PRA plan.

e. Ensure that FCC staff and other individuals designated to augment the FCC staff annually receive detailed education and training on their specific duties.

f. Develop, exercise and evaluate local PRA Plans.

g. Manage FCC communication procedures, processes and equipment to support local patient reception and distribution operations.

h. Ensure that representatives of NDMS member hospitals, local emergency management agencies, EMS, public safety, police and fire services are provided annual orientation to the PRA.

i. Ensure that individuals designated to augment the FCC staff receive detailed education and training on their specific duties.

j. Ensure that a Patient Reception Team (PRT) is developed for each PRA, and that each PRT remains viable through training and exercises.

k. Participate in nationwide periodic NDMS and ad-hoc local bed reporting exercises.

l. Collect bed availability data from each participating non-Federal hospital and report to the Department of Defense's Global Patient Movement Requirements Center (GPMRC), as directed.

m. Ensure that open communications and liaison are established with GPMRC for the receipt of regulating decisions, evacuation mission information and patient medical data, as applicable. Provide GPMRC with primary and alternate points of contact to ensure 24-hour availability, as needed.

n. Alert member hospitals when PRA activation is imminent and notify member hospitals when PRA activation has occurred.

o. Ensure that the FCC Director, the PRT, local EMS coordinators, all affected hospitals, higher headquarters and all other applicable agencies and individuals are notified when patients are regulated to the FCC.

p. Ensure an accounting method is in place to account for patients regulated but not yet received, in order not to overstate beds available.

q. Establish and maintain procedures to obtain vehicles and personnel on relatively short notice to transport patients in the PRA. Arrange local transportation to move patients from reception sites onward to local NDMS member hospitals.

r. Assume administrative responsibility for NDMS patients arriving in the PRA. Maintain the location and status of each patient receiving definitive care in the PRA.

s. Coordinate fiscal information to support the processing of civilian disaster financial claims reimbursement. Provide HHS or their designated representative with contact information to NDMS member hospitals to facilitate medical claims processing, as required. Provide specific claims processing instructions to NDMS member hospitals, as provided by the HHS or their designated representative. Provide patient validation and tracking data to the HHS or their designated representative. Collect appropriately billed charges for support services incurred by

the FCC during patient reception operations, and provide them through their chains of command to the Department of Homeland Security for reimbursement.

t. Assist in coordinating the return of NDMS patients who require en route medical care, as directed.

Annex I
GLOSSARY OF TERMS AND ABBREVIATIONS

1. Terms.

Activated Federal Coordinating Center. This status implies that FCC reimbursement for all patient reception activities is authorized. It signifies that patients are to be regulated, or have been regulated to a PRA under management of this FCC. Patients can be expected to arrive within 12-24 hours.

Alerted Federal Coordinating Center. Should patient requirements dictate the need for NDMS beds, an alerted PRA under management of an FCC could be among the next to receive patients. However, patients are currently NOT being regulated to this PRA. This status does not necessarily authorize reimbursement of FCC and/or PRA expenses incurred preparing for possible reception of patients. FCCs could expect at least 24-hour notice of patient arrival.

Available Beds. Beds that are vacant as of 2400 hrs of the day previous to the day of the report, to which GPMRC can regulate and to which patients can immediately be transported. They must be in a functioning medical treatment facility set up and ready for all aspects for the care of a patient. Available beds must include supporting space, equipment, medical material, ancillary and support services and staff to operate under normal circumstances. Excluded are transient patient beds, bassinets, incubators, and labor and recovery beds. Beds are reported in categories as instructed by GPMRC.

Bed Report. The submission of a hospital's real-time capacity to receive, admit, and treat patients from a disaster or war, or the submission of a FCCs capacity, including all available NDMS beds, for hospitalization.

Burns (SBN). Patients having burn injuries meeting the American Burn Association's (ABA) burn unit referral criteria, including (but not limited to) partial thickness burns of 10% or more of the total body surface: all patients with third-degree burns of 10% or more of the total body surface; or patients with significant burns involving the face, hands, feet, genitalia, perineum or major joints. Burn beds are generally defined as those associated with burn centers on the joint ABA and American College of Surgeons (ACS) verification list.

Capability. The maximum number of patients a facility can accommodate.

Capacity. The number of patients that a facility can accommodate at a given point in time.

Category. One of the specific areas of medical care used to identify the nature of a patient's illness/injury as well as to identify the capability/capacity of a hospital.

Critical Care (CC). Adult or pediatric patients requiring sophisticated intervention to restore or maintain life processes to their dynamic equilibrium. This involves the requirement to provide immediate and/or continuous attention and monitoring using specialized facilities, equipment and personnel. Critical care beds are generally defined as those in licensed intensive care units.

Federal Coordinating Center. A facility located in a metropolitan area of the United States responsible for day-to-day coordination of planning and operations in one or more assigned geographic NDMS Patient Reception Areas (PRA).

Federal Coordinating Center Work Group. Consists of one representative from each of the four partner agencies. It coordinates FCC training, exercises, assessments, communications, planning and operations for the NDMS.

Federal Coordinating Center Coordinator. A DOD, VA or other principle staff officer assigned to assist the FCC Director.

Federal Coordinating Center Director. A military medical treatment facility commander, medical center director, or other individual responsible for the management of an FCC and associated NDMS PRAs.

Medical Regulating. The actions and coordination necessary to arrange for the movement of patients through the levels of care. This process matches patients with a medical treatment facility that has the necessary health service support capabilities, and also ensures that bed space is available.

Medical/Surgery (MM-SS). Patients having, or suspected of having, medical illness or disorders, as well as patients having, or suspected of having, diseases or injuries normally treated by surgery, not coming within the purview of a more specific medical specialty. Medical/surgical beds are generally defined as those licensed, certified or otherwise authorized, with adequate space, equipment, medical materiel and ancillary support services, and staff to operate under normal circumstances. Excluded are transient patient beds, bassinets, incubators, labor beds and recovery beds.

National Disaster Medical System Executive Secretariat. Consists of one official from each of the four partner agencies. It provides management and supervision of the NDMS.

National Disaster Medical System Senior Policy Group. Consists of the Under Secretary, Department of Homeland Security, Emergency Preparedness and Response (Chairman); the Assistant Secretary of Defense (Health Affairs); the HHS Assistant Secretary of Public Health Emergency Preparedness, and the VA Under Secretary for Health. It determines policy and goals for the NDMS.

National Disaster Medical System Steering Committee. Local hospital, medical, public health, public safety, emergency management and emergency medical services officials, representatives of voluntary organizations, and elected officials organized in an NDMS PRA to assist in the preparation of local NDMS operating plans, planning, and execution of system exercises.

Patient Movement Items. Medical equipment and supplies used by the DOD to support a patient during evacuation

Patient Reception Area. A geographic locale containing one or more airfields; adequate patient staging facilities; and adequate local patient transport assets to support patient reception and transport to local voluntary, pre-identified, non-Federal, acute care hospitals capable of providing definitive care for victims of a domestic disaster, emergency, or military contingency.

Pediatrics (MC). Patients having, or suspected of having, diseases or injuries requiring the services of pediatric health care providers. Pediatric beds are generally defined as those supported by a licensed pediatrician.

Psychiatry (MP). Patients who require specialized psychiatric care in a medical treatment facility, including patients with disorders defined by the American Psychiatric Association as severe mental illness (schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, or autism). Psychiatric beds are generally defined as those supported by a licensed psychiatrist, or a licensed practice registered nurse, social worker, psychologist or professional counselor when those services are part of a treatment plan authorized by a licensed psychiatrist.

Staffed Bed. An accommodation in a functioning medical treatment facility that is currently set up and ready in all respects for the care of a patient. It must include supporting space, equipment, medical materiel, ancillary and support services, and staff to operate under normal circumstances. Excluded are transient patient beds, bassinets, incubators, labor beds, and recovery beds.

Throughput. The maximum number of patients that can be received at the NDMS patient reception area, off-loaded, staged, triaged, transported and admitted to the destination hospital (or hospitals of the NDMS) within any 24-hour period. This is an estimate, subjectively derived from various considerations such as reception site and local transportation limitations, personnel limitations for patient reception, staging and transport, as well as any other factors deemed relevant.

2. Abbreviations.

AE	Aeromedical Evacuation
AES	Aeromedical Evacuation System
AMC	Air Mobility Command
AOA	American Osteopathic Association
AOR	Area of Responsibility
ARC	American Red Cross
ARES	Amateur Radio Emergency Services
CAPT	Captain (U.S. Navy)
CC	Critical Care (bed reporting category)
CEO	Chief Executive Officer
CONUS	Continental United States
CRAF	Civil Reserve Air Fleet

CSU	Clearing Staging Unit
DFO	Disaster Field Office
DHS	Department of Homeland Security
DMAT	Disaster Medical Assistance Team
DOD	Department of Defense
DVA	Department of Veterans Affairs
EMS	Emergency Medical Services
EPC	Emergency Planning Committee
EP&R	Emergency Preparedness and Response
ERT-A	Emergency Response Team - Advanced
ESF	Emergency Support Function
ESF #1	Emergency Support Function #1 – Transportation
ESF #6	Emergency Support Function #6 – Mass Care
ESF #8	Emergency Support Function #8 – Health and Medical Services
EXORD	Execute (or Execution) Order
FCC	Federal Coordinating Center
FCO	Federal Coordinating Officer
FY	Fiscal Year
GPMRC	Global Patient Movement Requirements Center
HAM	Amateur Radio Operators
HAZMAT	Hazardous Materials
HLS	Homeland Security
IAW	In accordance with
IBA	Irving Burton Associates, Inc.
JCAHO	Joint Commission on Accreditation Of Healthcare Organizations

JCS	Joint Chiefs of Staff
JDOMS	Joint Director of Military Support
LFA	Lead Federal Agency
MARS	Military Affiliate Radio System
MC	Pediatrics (bed reporting category)
MCPS	Medical Claims Processing System
MHS	Military Healthcare System
MIACG	Medical Inter-Agency Coordinating Group
MM/SS	Medical/Surgical (bed reporting category)
MMRS	Metropolitan Medical Response System
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MP	Psychiatry (bed reporting category)
MPAT	Military Patient Administration Team
MST	Management Support Team
MTF	Military Medical Treatment Facility
NDMS	National Disaster Medical System
NECC	National Emergency Coordination Center
NMCC	National Military Command Center
NOK	Next of Kin
NRP	National Response Plan
OASD/HA	Office of the Assistant Secretary of Defense, Health Affairs
OPLAN	Operations Plan
OSC	Operations Support Center
PMI	Patient Movement Items

Annex J
FEDERAL COORDINATING CENTER (FCC) PATIENT RECEPTION AREA (PRA) SELF ASSESSMENT SURVEY

PRA Location / Area of Responsibility: _____

_____

FCC Address: _____

_____

_____

FCC Area Coordinator: _____

Phone: _____ Fax: _____

E-mail: _____

Name of Person(s) Completing Survey: _____

_____

Date Completed: _____

FCC Director's Review:

_____ _____

Name Signature

_____

Date

I. FCC Command, Control & Communications

1. How many full time and/or augmentation personnel are assigned or detailed to the FCC that manages this PRA?

2. Does the FCC manage more than one PRA? ☐Yes ☐ No ☐ Unknown

3. If the FCC manages more than one PRA, are sufficient personnel dedicated to manage operations at this PRA? ☐Yes ☐ No ☐ Unknown

4. Are key FCC staff members subject to military mobilization? ☐Yes ☐ No ☐ Unknown

5. Are sufficient financial resources available to maintain, train, equip and exercise the FCC? ☐Yes ☐ No ☐ Unknown

6. Are sufficient administrative resources (e.g., space, furniture, supplies) available to maintain, train and exercise the FCC? ☐Yes ☐ No ☐ Unknown

7. Are sufficient information technology resources available to maintain, train and exercise the FCC? ☐Yes ☐ No ☐ Unknown

8. Are sufficient primary and alternative communications available to the FCC? ☐Yes ☐ No ☐ Unknown

9. Does the FCC maintain contact with the following?

a. Local NDMS Steering Committee ☐Yes ☐ No ☐ Unknown

b. Local volunteer organizations (e.g., the American Red Cross, Salvation Army) ☐Yes ☐ No ☐ Unknown

c. Local Emergency Medical Services ☐Yes ☐ No ☐ Unknown

d. Local public health authorities, as applicable ☐Yes ☐ No ☐ Unknown

e. DOD Global Patient Movement Requirements Center ☐Yes ☐ No ☐ Unknown

10. Have tracking mechanisms been established to account for expenses incurred to support FCC staff training, exercises, equipping, and operations? ☐Yes ☐ No ☐ Unknown

11. Have tracking mechanisms been established to account for expenses incurred to support local patient reception and distribution operations? ☐Yes ☐ No ☐ Unknown

12. Are lines of authority, roles and responsibilities for the FCC staff, the Patient Reception Team(s), and other local authorities, companies and agencies documented? ☐Yes ☐ No ☐ Unknown

13. Are FCC message control measures and required notifications adequately established? ☐Yes ☐ No ☐ Unknown

14. Have TRAC2ES accounts been established for sufficient numbers of FCC staff personnel? ☐Yes ☐ No ☐ Unknown

15. Have contacts been established with the TRICARE Regional Offices? ☐Yes ☐ No ☐ Unknown

16. Is sufficient support provided by U.S. NORTHCOM Joint Regional Medical Planners? ☐Yes ☐ No ☐ Unknown

17. Is sufficient support provided by a local NDMS Steering Committee? ☐Yes ☐ No ☐ Unknown

18. What agencies constitute and/or support the local NDMS Steering Committee?

19. Have procedures been established to guide media relations? ☐Yes ☐ No ☐ Unknown

20. Is accurate FCC contact information (such as the FCC Area Coordinator, 24/7 FCC phone numbers and addresses) maintained in TRAC2ES? ☐Yes ☐ No ☐ Unknown

21. Are there sufficient primary and alternative means of communications maintained among the FCC, Patient Reception Team(s), local hospitals, and other local authorities? ☐Yes ☐ No ☐ Unknown

22. Has a PRA plan been developed? ☐Yes ☐ No ☐ Unknown

23. Has a PRA plan been reviewed/updated on an annual basis? ☐Yes ☐ No ☐ Unknown

24. Has the PRA plan been integrated into community emergency preparedness plans? ☐Yes ☐ No ☐ Unknown

Comments:

II. Patient Reception and Distribution

1. Does the PRA plan address following areas?

a. Contact information for Patient Reception Team(s) ☐Yes ☐ No ☐ Unknown

b. Plans and procedures for recall and mustering of Patient Reception Team(s) ☐Yes ☐ No ☐ Unknown

c. Identification of local ambulance resources, inventories, capabilities, points of contact, phone numbers, written agreements or contractual requirements (if any) ☐Yes ☐ No ☐ Unknown

d. Identification of local bus or taxi resources, inventories, capabilities, points of contact, phone numbers, written agreements or contractual requirements (if any) ☐Yes ☐ No ☐ Unknown

e. Identification of additional patient movement items, such as litters and blankets, etc. ☐Yes ☐ No ☐ Unknown

f. Patient Reception Team(s) plans, processes and procedures for patient unloading patients ☐Yes ☐ No ☐ Unknown

g. Patient Reception Team(s) plans, processes and procedures for staging, holding and re-triaging patients at the airfield, bus and/or train terminal(s) ☐Yes ☐ No ☐ Unknown

h. Resources to support the Patient Reception Team(s), such as shuttle vehicles ☐Yes ☐ No ☐ Unknown

i. Night and/or weekend operations ☐Yes ☐ No ☐ Unknown

j. Inclement weather contingencies ☐Yes ☐ No ☐ Unknown

k. Processes and procedures for patient identification and tracking within the PRA ☐Yes ☐ No ☐ Unknown

l. Record keeping within the PRA ☐Yes ☐ No ☐ Unknown

2. Does the PRA plan rely exclusively on a Mobile Aeromedical Staging Facility (MASF) or on the use of an NDMS Disaster Medical Assistance Team for patient reception activities? ☐Yes ☐ No ☐ Unknown

3. What commercial or military airfields support the PRA?

Primary Airfield:

Secondary Airfield:

Tertiary Airfield:

4. Are these primary airfields accurately reflected in TRAC2ES? ☐Yes ☐ No ☐ Unknown

5. Have primary and alternative airfield authorities been coordinated with regarding the following?

a. Identification of key points of contact / contact information ☐Yes ☐ No ☐ Unknown

b. Designated patient unloading and staging area(s) ☐Yes ☐ No ☐ Unknown

c. Any security issues / access to patient unloading and staging area(s) ☐Yes ☐ No ☐ Unknown

d. Potential airfield closures or other operational constraints ☐Yes ☐ No ☐ Unknown

e. Patient unloading equipment storage, access and use ☐Yes ☐ No ☐ Unknown

f. Coordination with airfield medical facilities/personnel (if applicable) ☐Yes ☐ No ☐ Unknown

6. Have bus and train terminal authorities been coordinated with regarding the following?

a. Identification of key points of contact / contact information ☐Yes ☐ No ☐ Unknown

b. Designated patient unloading and staging area(s) ☐Yes ☐ No ☐ Unknown

c. Any security issues / access to patient unloading and staging area(s) ☐Yes ☐ No ☐ Unknown

d. Potential operational constraints ☐Yes ☐ No ☐ Unknown

e. Patient unloading equipment storage, access and use ☐Yes ☐ No ☐ Unknown

f. Coordination with terminal medical facilities/personnel (if applicable) ☐Yes ☐ No ☐ Unknown

7. Have procedures been outlined to coordinate patient follow-on moves and/or return of patients to destinations outside the PRA? ☐Yes ☐ No ☐ Unknown

8. Are guidelines in place to help to estimate the maximum number of NDMS patients that can be received at this PRA, off-loaded, staged, triaged, transported and admitted to the destination hospitals of the NDMS within any 24-hour period (i.e., "Throughput")? ☐Yes ☐ No ☐ Unknown

9. Has the local community been consulted on normal daily community ambulance use, to base ambulance availability estimates for calculating "Throughput"? ☐Yes ☐ No ☐ Unknown

10. Has the estimated "Throughput" been tested in an exercise within the past three years? ☐Yes ☐ No ☐ Unknown

11. Have the factors that limit the sustainability of this PRA's throughput been identified and mitigated to the extent possible? ☐Yes ☐ No ☐ Unknown

12. What additional resources, authorities or processes would be useful to improve, expand or further sustain the patient reception and distribution capabilities for this PRA? ☐Yes ☐ No ☐ Unknown

Comments:

III. Definitive Medical Care

1. Have all local acute-care civilian hospitals with more than 100 operational beds within 50 miles and/or one hour drive, as well as other hospitals as appropriate, been contacted and invited to join the NDMS within the past three years? ☐Yes ☐ No ☐ Unknown

2. Are signed Memorandums of Agreement (MOAs) maintained for all participating local hospitals? ☐Yes ☐ No ☐ Unknown

3. How many MOAs signed within the last three years are on file for this PRA?

4. What is the total minimum number of beds available (according to MOAs) for this PRA?

5. What is the total maximum number of beds available (according to MOAs) for this PRA?

6. Has a PRA plan been developed and coordinated with all participating local hospitals and the community? ☐Yes ☐ No ☐ Unknown

7. Have the following been *considered* by participating NDMS hospitals?

a. In-service training on expansion of inpatient capacity to support NDMS? ☐Yes ☐ No ☐ Unknown

b. Cancellation of elective surgeries in order to make additional beds available? ☐Yes ☐ No ☐ Unknown

c. Inpatient discharge protocols to create additional beds? ☐Yes ☐ No ☐ Unknown

d. Hospital plans for expansion? ☐Yes ☐ No ☐ Unknown

e. Expanded staff availability? ☐Yes ☐ No ☐ Unknown

f. Calculated loss of clinical/support staff due to Reserve Mobility Status Activation and/or other Federal, State or Local obligations? ☐Yes ☐ No ☐ Unknown

8. Have any special procedures been established for admission and disposition of NDMS patients at participating hospitals? ☐Yes ☐ No ☐ Unknown

9. Do participating hospitals understand the role of the Military Patient Administration Team (MPAT), if applicable? ☐Yes ☐ No ☐ Unknown

10. Do participating hospitals know how to contact the nearest military medical treatment facility(s)? ☐Yes ☐ No ☐ Unknown

11. Are contingency plans in place to coordinate food, lodging and transport for NDMS patients requiring outpatient services? ☐Yes ☐ No ☐ Unknown

12. Are contingency plans in place to coordinate food, lodging and transport for NDMS non-medical attendants and/or family members? ☐Yes ☐ No ☐ Unknown

13. Are local information packets available for distribution to NDMS patients, non-medical attendants and/or family members? ☐Yes ☐ No ☐ Unknown

14. Are all participating hospitals versed in their responsibilities regarding patient tracking? ☐Yes ☐ No ☐ Unknown

15. Are all participating hospitals versed in medical claims processing? ☐Yes ☐ No ☐ Unknown

16. What additional resources, authorities or processes would be useful to improve or expand definitive care capabilities for this PRA? ☐Yes ☐ No ☐ Unknown

Comments:

IV. Training & Exercises

1. Does the FCC maintain a training and exercise plan and/or calendar for this PRA? ☐Yes ☐ No ☐ Unknown

2. Are FCC PRA training and exercise objectives articulated? ☐Yes ☐ No ☐ Unknown

3. Did the FCC formulate a training and exercise budget request in the past year? ☐Yes ☐ No ☐ Unknown

4. Did the FCC provide an orientation to the PRA plan to representatives of the NDMS member hospitals, as well as to representatives of local emergency management agencies, EMS agencies, police and fire services within the past year? ☐Yes ☐ No ☐ Unknown

5. Has the FCC Area Coordinator briefed the NDMS member hospitals that, while not officially part of the billing process, the FCC is available to assist in processing claims for reimbursement? ☐Yes ☐ No ☐ Unknown

6. Have all NDMS hospitals participated in a large-scale NDMS patient reception exercise within the last three years? ☐Yes ☐ No ☐ Unknown

7. Have all NDMS hospitals participated in a patient reception exercise, tabletop, functional area drill, team training, or other PRA-related event in the past year? ☐Yes ☐ No ☐ Unknown

8. If the answer to question 7 is no, what percent of all NDMS hospitals have participated in a patient reception exercise, tabletop, functional area drill, team training, or other PRA-related event in the past year? ☐Yes ☐ No ☐ Unknown

9. Did the FCC ensure that individuals designated to augment the FCC staff received detailed education and training on their specific duties within the past year? ☐Yes ☐ No ☐ Unknown

10. Have sufficient numbers of FCC personnel received sufficient TRAC2ES training to accomplish their FCC duties? ☐Yes ☐ No ☐ Unknown

11. Have sufficient numbers of FCC personnel received training with any specialized communications equipment (e.g., HF radio)? ☐Yes ☐ No ☐ Unknown

12. Did the FCC conduct group training exercises or drills within the past year to ensure the preparedness of teams (e.g., the Patient Reception Team)? ☐Yes ☐ No ☐ Unknown

13. Did the FCC participate in a full-scale NDMS patient reception exercise in this PRA at least once in the past three years? ☐Yes ☐ No ☐ Unknown

14. Has a PRA plan been subject of a detailed table-top exercise? ☐Yes ☐ No ☐ Unknown

15. Are training events documented? ☐Yes ☐ No ☐ Unknown

16. Are deficiencies and lessons learned during exercises tracked and reviewed for closure? ☐Yes ☐ No ☐ Unknown

Comments:

Annex K
FEDERAL COORDINATING CENTERS (FCCs)

FACILITY	FEDERAL REGION	STATE
Naval Ambulatory Care Center (Groton)	1	CT
VAMC Bedford	1	MA
VAMC Northampton	1	MA
Naval Health Care New England (Newport)	1	RI
VAMC San Juan	2	PR
VAMC Albany	2	NY
VAMC Buffalo	2	NY
VAMC Syracuse	2	NY
VA Hudson Valley HCS (Castle Point)	3	NY
VA New York Harbor HCS (New York)	3	NY
VAMC Northport	3	NY
USAF 436 Medical Group (Dover AFB)	3	DE
VA New Jersey HCS (Lyons)	3	NJ
VAMC Philadelphia	3	PA
VA Pittsburgh HCS	3	PA
VAMC Holmes (Richmond)	3	VA
Naval Medical Center Portsmouth (Norfolk)	3	VA
VAMC Birmingham	4	AL
VA Central Arkansas HCS (Little Rock)	4	AR
VAMC Miami	4	FL
VAMC Haley (Tampa)	4	FL
Naval Hospital Jacksonville	4	FL
VAMC Atlanta	4	GA
Eisenhower Army Medical Center (Ft Gordon)	4	GA
VAMC Lexington	4	KY
VAMC Louisville	4	KY
VAMC Montgomery (Jackson)	4	MS
USAF 81 AMDS (Keesler AFB)	4	MS
VAMC Hefner (Salisbury)	4	NC
VAMC Durham	4	NC
Moncrief Army Hospital (Ft Jackson)	4	SC
Naval Hospital Charleston	4	SC
VA Tennessee Valley HCS (Nashville)	4	TN
Walter Reed Army Medical Center	5	DC
Naval Hospital Great Lakes (Chicago)	5	IL
USAF 375 Medical Group (Scott AFB)	5	IL
VAMC Roudebush (Indianapolis)	5	IN
National Naval Medical Center (Bethesda)	5	MD
VAMC Dingell (Detroit)	5	MI
VAMC Minneapolis	5	MN
VAMC Stokes (Cleveland)	5	OH

FACILITY	FEDERAL REGION	STATE
USAF 74 Medical Group (Wright-Patterson AFB)	5	OH
USAF 89 Medical Group (Andrews AFB)	5	VA
VAMC Zablocki (Milwaukee)	5	WI
VAMC New Orleans	6	LA
VAMC Brooks (Shreveport)	6	LA
VA New Mexico HCS (Albuquerque)	6	NM
VAMC Oklahoma City	6	OK
Beaumont Army Medical Center (Ft Bliss)	6	TX
VAMC DeBakey (Houston)	6	TX
VA South Texas HCS (San Antonio)	6	TX
VA North Texas HCS (Dallas)	6	TX
VA Central Iowa HCS (Des Moines)	7	IA
VAMC Dole (Wichita)	7	KS
VAMC Kansas City	7	MO
USAF 55 Medical Group (Offutt AFB)	7	NE
Evans Army Hospital (Ft Carson)	8	CO
VA Salt Lake City HCS	8	UT
VA Southern Arizona HCS (Tucson)	9	AZ
VAMC San Francisco	9	CA
VA Long Beach HCS	9	CA
Naval Hospital Camp Pendleton	9	CA
USAF 60 AMDS (Travis AFB)	9	CA
Naval Medical Center San Diego	9	CA
Tripler Army Medical Center (Honolulu)	9	HI
USAF 56 Medical Group (Luke AFB)	9	AZ
VAMC Portland	10	OR
Madigan Army Medical Center (Ft Lewis)	10	WA

Annex L
REFERENCES

- 6 U.S.C. 313, Public Law 107-296, The Homeland Security Act 2002
- 42 U.S.C. 5121 et seq, Public Law 100-707, The Robert T. Stafford Disaster Relief and Assistance Act
- 42 U.S.C. 243, Public Law 78-410, Public Health Service Act
- 42 U.S.C. 300hh-11, Public Law 108-188, Public Health Security and bioterrorism Preparedness and Response Act of 2002
- 38 U.S.C. 8111A, Public Law 97-174, VA and DOD Health Resources Sharing and Emergency Operations Act
- 38 U.S.C. 1785, Public Law 107-287, The Department of Veterans Affairs Emergency Preparedness Act of 2002
- 42 U.S.C. 1320d, Public Law 104-191, Health Insurance Portability and Accountability Act of 1996
- Executive Order 12656, Assignment of Emergency Preparedness Responsibilities (18 November 1988)
- National Response Plan (December 2004)
- Homeland Security Council Planning Scenarios (July 2004)
- MOA, National Disaster Medical System (24 October 2005)
- MOU between VA and DOD Regarding the Furnishing of Health-Care Services to Members of the Armed Forces in the Event of a War or National Emergency (December 1982)
- DOD Directive 3025.1, Military Support to Civil Authorities (15 January 1993)
- DOD Directive 5158.4, US Transportation Command (8 January 1993)
- DOD Directive 6000.12, Health Services Operations and Readiness (29 April 1996)
- DOD Instruction 6000.11, Patient Movement (9 September 1998)
- ASD(HA) Memorandum, Lead Agent Guidelines (7 November 1995)
- USJFCOM Functional Plan 2508, Integrated Continental US (CONUS) Medical Operations Plan (15 July 1998)
- Metropolitan Medical Strike Team Field Operating Guide (November 1998)
- NDMS Patient Movement Concept of Operations Plan (Draft)
- Civil Reserve Air Fleet Contract, Attachment 9, Paragraph 2.20 (FY2000)